Christian Health Association Of Kenya

CHAK
CHRISTIAN HEALTH ASSOCIATION OF KENYA
REV 22 V.2

Annual Report 2016

Celebrating
70
Years
of Quality
Health Care
1946-2016

"Promoting access to quality health care"

Christian Health Association of Kenya

Annual Report 2016

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Identity, purpose, programs and partnerships

Identity

CHAK is a national faith based organization of Protestant Churches' health institutions and programs from all counties of Kenya which was established in 1946 and is dedicated to promoting universal access to quality health care.

Vision

Quality Healthcare for all to the glory of God

Mission

To facilitate provision of quality health services through health systems strengthening, innovative health programs, training, advocacy and partnerships as a witness to the healing ministry of Christ

Values

- Integrity
- Transparency
- Accountability
- Professionalism
- Innovation
- Equity

Purpose

The purpose of CHAK is to promote access to quality health care by facilitating health facilities to deliver accessible, comprehensive, quality health services to the people of Kenya in accordance with Christian values, professional ethics and national health sector policies. CHAK also engages communities to empower them seek and access quality health care.

Strategic directions

The CHAK Strategic Plan has its core objectives clustered into five strategic directions which include:

1. Health service delivery
2. Health systems strengthening
3. Capacity Building and Research
4. Advocacy and Partnerships.
5. Sustainable financing and resource management

Programs

CHAK runs a wide range of health service delivery and systems strengthening programs with the goal of promoting universal access to quality health care. These include:

- HIV&AIDS prevention, care and treatment
- HIV&AIDS stigma mitigation and promotion of legal and human rights
- Tuberculosis (TB) treatment, defaulter and contact tracing and TB/HIV co-infection management
- Malaria prevention and management
- Maternal, Neonatal and Child Health services
- Reproductive Health and Family Planning
- Diabetes management
- Hypertension education and screening at community level and referral linkages for management
- Advocacy, research and communication
- Hospital quality management program
- Partnerships and County Governments engagement
- Sustainable health care financing and grant management
- Health systems strengthening

a) Medical equipment program supporting needs assessment, sourcing, installation and maintenance
b) Human resources for health capacity development and systems strengthening
c) Governance, leadership and management support for member health facilities
d) ICT systems strengthening including Hospital Management System
c) Strategic Information (M&E) and EMR (Electronic Medical Records System)

Partnerships

- CHAK embraces strategic partnerships with donors, UN agencies, Government, MOH, county health departments, NHIF, FBOs, NGOs, private sector, academic and eesearch institutions and communities.
- CHAK is a founder member who hosts and supports the Secretariat of the Africa Christian Health Associations Platform (ACHAP) and the Institute for Family Medicine (INFAMED)

Donor partners

CHAK has had successful partnership with a variety of donor partners including PEPFAR, CDC, USAID, Global Fund, Gates Foundation, GIZ, Bread for the World (Germany), Packard Foundation, DANIDA, Astra Zeneca, Novo Nordisk, Norvatis and OSI Foundation.

Membership analysis

CHAK membership includes hospitals, health centres, dispensaries, church health programmes, community based health care programmes and medical training colleges from all over Kenya. As at the close of 2016, CHAK had a total of 579 member health units affiliated to 50 Protestant Churches denominations.

CHAK membership is grouped into four regions covering the whole country which are:

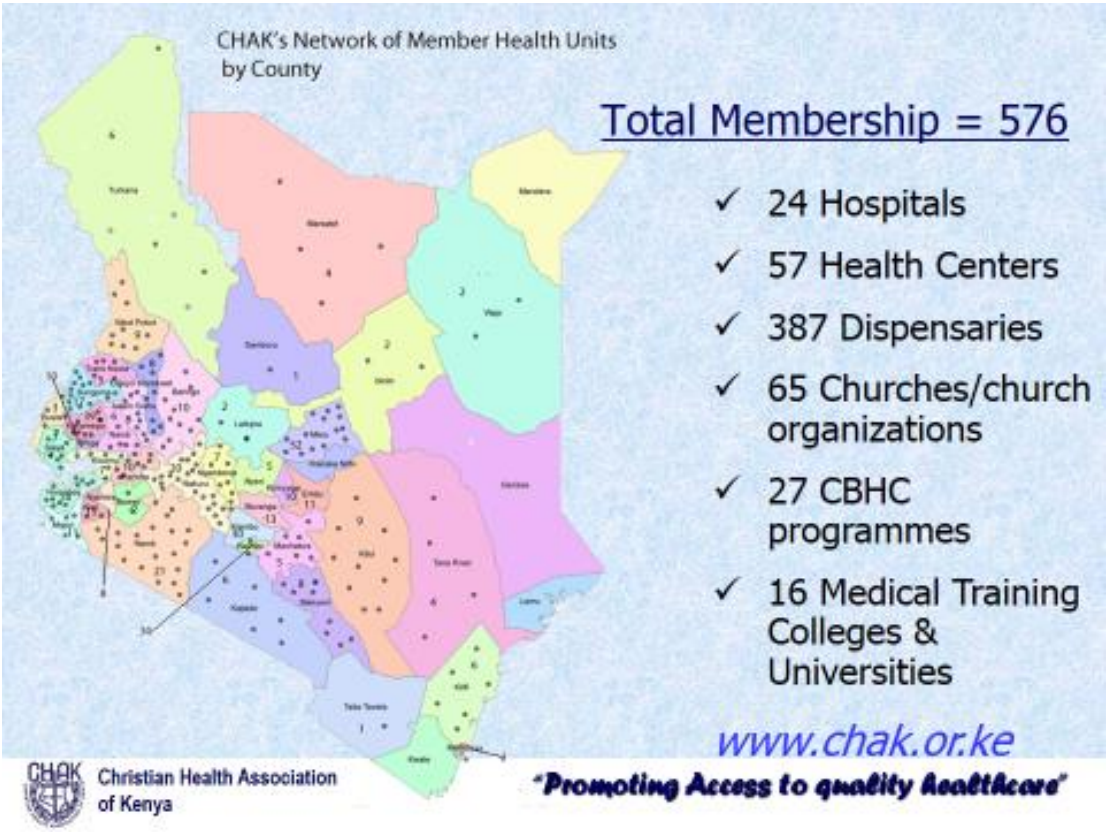
- Eastern/North Eastern Region
- Central/Nairobi/South East and Coast Region
- Western/North Rift Region
- Nyanza/South Rift Region

The membership analysed per category is as below;

- Hospitals - 23
- Health Centers - 58
- Dispensaries - 389
- Community Based Health Care Programs - 28
- Churches and Church Organizations - 65
- Medical Training Colleges & Universities - 16

Total - 579

Church Denomination affiliations - 50



Acknowledgement

CHAK is grateful to the Government of Kenya, Ministry of Health, County Governments Health Departments, development partners and other health sector partners for collaboration in health initiatives in Kenya.

We also value our regional partnership in the Africa Christian Health Associations Platform (ACHAP) and international partnerships through CCIH, WCC and other international agencies.

We appreciate our technical partners, consortium members, CHAK Member Health Units, churches and communities.

List of abbreviations

ACHAP.....Africa Christian Health Associations Platform
ADR .....Alternative Dispute Resolution
AOPs.....Annual Operational Plans
ASRH. .....Adolescent Sexual Reproductive Health
CA Cervix.....Cancer of the Cervix
CRS. .....Catholic Relief Services
CHV .....Community Health Volunteers
CSO .....Civil Society Organisation
CQI .....Clinical Quality Improvement
CDC. .....Centres for Disease Control
CHAP. .....CHAK HIV/AIDS Programme
CHAM.....Christian Health Association of Malawi
CU .....Community Units
CB DOT .....Community Based Direct Observation Treatment
CHEW. .....Community Health Extension Worker
CWC .....Child Welfare Clinic
CMMB.....Catholic Medical Missions Board
CHW.....Community Health Worker
CHAZ.....Christian Health Association of Zambia
CHAN .....Christian Health Association of Nigeria
CBHC.....Community Based Health Centre
CBTS .....Community Based Treatment Strategy
CDC .....Centre for Disease Control
CD4 .....Cluster of Differentiation
CHAP.....CHAK HIV/AIDS Project
CHEWS .....Community Health Extension Workers
CMMB.....Catholic medical Missions Board
CME .....Continuous Medical Education
CPD .....Continuous Professional Development
CRAG.....Cryptococcal Antigen
CQI .....Continuous Quality Improvement
DHMT.....District Health Management Team
DTC. .....Diagnostic Testing and Counseling
DBS.....Dry Blood Sample
DIFAEM.....(German Institute for Medical Mission)
DNCD.....Department of Non Communicable Diseases
DDIU .....Data Demand for Information Use
DOTS.....Direct Observed Treatment Strategy
DNA.....Deoxyribonucleic Acid
EMR .....Electronic Medical Records
EMTCT .....Elimination of Mother To Child Transmission of HIV/AIDS
EED .....Evangelisher Entwicklungsdienst (English: Church Development Service)
EXCO .....Executive Committee
EPN .....Ecumenical Pharmaceutical Network
FANC. .....Focused Ante Natal Care
FBHS.....Faith Based Health Services
FPNC.....Focused Post Natal Care
GCLP.....Good Clinical Laboratory Practices
HAART.....Highly Active Anti-Retroviral Therapy
HEI.....HIV Exposed Infants
HRSA .....Health Resources and Services Administration
HIV .....Human Immunodeficiency Virus
HTC .....HIV Testing and Counselling
HSS .....Health System Strengthening
HRH.....Human Resources for Health
HSSF. .....Health Sector Service Fund
HCW.....Health Care Worker
HEI.....HIV Exposed Infants
HTC .....HIV Testing and Counseling
IC .....Infection Control
ICC.....Inter Agency Coordinating Committee
ICF .....Intensified Case Finding
IPC .....Infection Prevention and Control
IPT.....Isoniazid Preventive Therapy
IYCF .....Infant Young Child Feeding
IHV .....Institute of Human Virology
IMA.....Interchurch Medical Assistance
IMCI. .....Integrated Management of Childhood Illnesses
INFA-MED.....Institute of Family Medicine
KAIS .....Kenya AIDS Indicator Survey
KCCB .....Kenya Conference of Catholic Bishops
KEMSA .....Kenya Medical Supplies Agency
KEPI.....Kenya Expanded Programme for Immunization
KNASP .....Kenya National AIDS Strategic Plan

KEPI.....Kenya Expanded Programme on Immunisation
KQMH .....Kenya Quality Model for Health
LAN.....Local Area Network
LTFU .....Lost To Follow Up
LPTF.....Local Partner Treatment facilities
MTC.....Medical Training College
MDT.....Multi Displinary Team
MDR .....Multi Drug Resistant
MOMS .....Ministry of Medical Services
MNCH .....Maternal Newborn Child Health
MOPHS.....Ministry of Public Health and Sanitation
MOH DOMC. .....Ministry of Health Department of Malaria Control
MEDS.....Mission for Essential Drugs & Supplies
MHU.....Member Health Unit
MoH.....Ministry of Health
MDR .....Multiple Drug Resistance
MEDS.....Mission for Essential Drugs and Supplies
NASCOP. .....National AIDS/STDs Control Programme
NCD.....Non Communicable Disease
NHIF. .....National Hospital Insurance Fund
NHRL.....National HIV Reference Laboratory
OI.....Opportunistic Infections
OJT.....On Job Training
PSSG .....Psycho Social Support Groups
PEP.....Post Exposure Prophylaxis
PR. .....Principal Recipient
PEPFAR .....US President's Emergency Plan for AIDS Relief
PLWHAs.....People Living With HIV/AIDS
PMCT.....Prevention of Mother to Child Transmission of HIV
PHMT.....Provincial Health Management Team
PITC .....Provider Initiated Testing and Counseling
PWP.....Prevention With Positives
PCEA.....Presbyterian Church of East Africa
PCR.....Polymerase Chain Reaction
PEP.....Post- Exposure Prophylaxis
PEPFAR .....Presidents Emergency Plan for AIDS Relief
PITC .....Provider Initiated Testing and Counselling
PLHIV.....Persons Living with HIV
PwP.....Prevention with Positives
QI.....Quality Improvement
RH.....Reproductive Health
RCC.....Regional Coordinating Committee
SI.....Strategic Information
TB Rx .....TB Treatment
TB .....Tuberculosis
TOT.....Training of Trainers
UCMB. .....Uganda Catholic Medical Bureau
UPMB. .....Uganda Protestant Medical Bureau
USG .....United States Government
WHO .....World Health Organisation

Definition of Terms

IQ care.....International Quality Care Patient Management and Monitoring System
IQ Compile .....International Quality Care system that helps to aggregate data and facilitate transmission to Kenya Program Management System (KePMS)
IQ SMS.....International Quality Short Message Services
IQ Report .....This is a web-based reporting and data warehouse tool
IQ Train.....This is a utility that captures training data
IQ Tools .....This is a robust data analysis and reporting application

Summary of key accomplishments

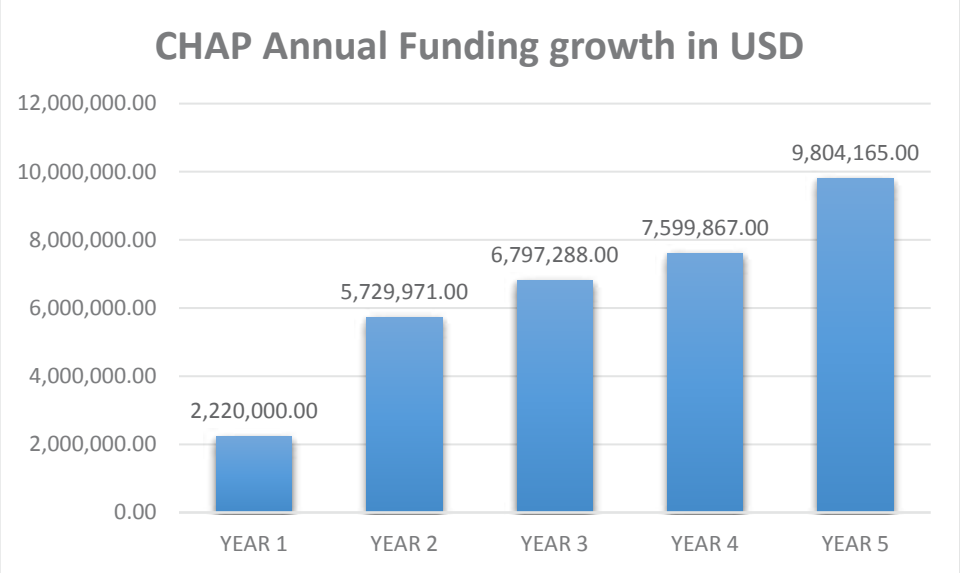
CHAP 2011-2016 service delivery achievements

Key areas of interest	Performance (September 2011 TO December 2016)				
	YR 1	YR 2	YR 3	YR 4	YR 5
No. of health facilities	6 (large)	57	57	55	**54**
Current on care	26,454	34,240	39,450	41,429	**42,949**
Current care adult	20,992	30,325	35,694	37,934	**39,714**
Current care paediatric	5,462	3,915	3,756	3,495	**3,235**
Current ART	16,754	30,345	36,468	38,461	**42,186**
Current ART adult	14,711	27,405	33,092	35,245	**39,057**
Current ART paediatric	2,043	2,940	3,376	3,216	**3,129**
Viral suppression adult (20+)				90%	**95%**
Viral suppression paediatric				overall	**86%**
Cumulative retention		79.1%	78.3%	81.7%	**78%**
HIV testing services	21,235	146,767	156,850	288,655	**301,500**
Mother to child transmission		**6.1%**	**4.4%**	**< 5%**	**< 5%**

The achievements are in line with the UNAIDS 90-90-90 targets of ensuring that at least 90 per cent of patients living with HIV are aware of their status, 90 per cent of those of known HIV positive status are on ART, and 90 per cent of those on ART are virally suppressed.

By the end of December 2016, the project had provided HIV testing services to over 900,000 clients with over 20,000 of those newly identified as positive linked to HIV care. By the end of December 2016, 98 per cent of adults on care and 97 per cent of pediatrics on care were on ART, with an overall project viral suppression of over 90 per cent.

CHAK HIV/AIDS Project annual funding growth over five years (Total = USD32.1m)



CHAK member health network health service delivery performance 2016 (Data source: MOH-DHIS2)

Key areas of interest	Performance
Hypertension	
Number of persons educated on Hypertension and it's risk factors	618,735
Number of persons screened for Hypertension	440,817
Desktop computers distributed for data collection	20
Tents distributed to Health facilities for community screening for Hypertension	10
Diabetes	
Number of newly diagnosed persons with Type 2 Diabetes	1,157

Key areas of interest	Performance
HIV Care and treatment	
Current care	217,015
Current ART	215,727
HIV Testing Services	706,573
Testing HIV Positive	21,846
Total on PMTCT Prophylaxis	25,709
12 Months Retention	78%
MNCH	
New ANC clients	386,946
Pregnant women completing 4 ANC visits	201,609
Total Skilled Birth deliveries	255,825
Fully immunized Children under 1 year old	131,931
Family planning	
Receiving Family planning	1,261,224

Summary of equipment and supplies support by CHAK HIV/ AIDS Project to implementing sites (2013-2016)

Summary of CHAK HIV/AIDS Project (CHAP) equipment and supplies support to faith based health facilities from 2013-2016

Items specifications	Quantities 2016	Quantities 2015	Quantities 2014	Quantities 2013	Total to Sites
Laboratory equipment					
Class II biological safety cabinet	11	6	2		19
Blood bank refrigerator	2	1	2		5
Cd4 machine		1	2	1	4
Haematology analyser			5	1	6
Biochemistry analyser			6		6
HP Proliant DL380 server	3	3	7	10	23
Cooler boxes at least 12L	56		17		73
Seca Adult scales + BMI & stadiometer	10	2	25		37
Seca baby digital scales	10	2	5		17
Chemical and biological spill kits	50				50
Lab chairs with back rest	50				50
Waterbath	11	1			12
Examination couch			3		18
Single channel pipette Vol 20-200ul	30	5			35
A/c (18000-24000 btu)	30	5			35
Waste disposal bins - Colour coded	50	74	70		194
Microscope olympus cx22 led.	13	2	5		20
BP machines		15			15
Pharmacy fridges		7	20		27
Pulse Oxymeters		55	70		125
TB masks		120			120
Wheelchairs		2			2
Stethoscopes		5	10		15
Drug cabinets		8			8
Desktop computers		20	33	57	110
Electrolyte Analyser Humalyte			2	1	3
Metal filing cabinets			50		50
Hb meters			4		4
Centrifuges			10		10
Thermometers			43		43
Sanitizer dispensers			10		10
Shaker/rocker			2		2
Other equipment					
Motorbikes	6	6	5	2	19
Solar systems and batteries	1		1		2
Photocopiers	3	1	5	7	16

Chairman's Report

Introduction

The year 2016 was the final year of implementation of the Revised CHAK Strategic Plan 2011 – 2016 and the third year of implementation of the second phase three-year programme.

It was also a significant year in CHAK's developmental milestones as we attained 70 years.

Membership continued to grow with the total membership reaching 579 with affiliations to 50 church denominations. The membership includes 24 hospitals, 58 health centres, 389 dispensaries, 16 Medical Training Colleges and Universities offering medical programmes, 28 CBHC programmes and 65 church organizations.

The CHAK Strategic Plan 2011-2016 came to an end in December 2016 and end-term external evaluation was conducted. Through a participatory consultative process, CHAK has utilized the evaluation recommendations and feedback from members and other key stakeholders to develop a new Strategic Plan for the period 2017-2022.

The first three-year programme has been developed and implementation started from January 2017 through funding from Bread for the World, Germany.

During the year, CHAK successfully completed implementation of the five-year comprehensive HIV&AIDS care and treatment project funded by PEPFAR through CDC for church health facilities in 18 counties in Eastern, Central, Nairobi and Coast regions.

The 54 implementing health facilities had enrolled over 43,000 people living with HIV/AIDS into care and treatment. At the conclusion of the five years in September 2016, CHAK was awarded a project extension for six months to March 2017 with an additional funding of USD2.4m.

The project's achievements were disseminated jointly with other four similar projects implemented by other faith based organizations at a forum that attracted 360 participants from Government, donors, partners and faith based organizations.

The successes and lessons learned from five years of great service were disseminated at the joint forum and were well received and appreciated by Government, donors, networks of people living with HIV and other stakeholders in the HIV response in Kenya.

CDC has appreciated CHAK for the accomplishment and stewardship of the project and awarded us another five year follow-on project named CHAP-Uzima which has expanded scope and mandate.

The Healthy Heart Africa hypertension project funded by AstraZeneca supported a unique health facility-church-community partnership model in rolling out hypertension education and awareness, screening and treatment linkages that screened over one million people in 22 counties.

The project achievements demonstrate the extensive reach and power of the church in mobilization and service provision. Following the successful pilot, CHAK was awarded a three-year project focusing on hypertension screening, quality treatment and follow-up to ensure good control.

Global Fund-supported projects addressing TB and Malaria in Machakos, Nyamira and Vihiga counties did well within the year. These have not only provided CHAK an opportunity to address TB and Malaria, but have also provided a platform for strengthening partnership with County Governments and MOH.

CHAK facilitated successful advocacy and engagement with NHIF for MHUs accreditation and rebates review. We also discussed partnership with CHAK and Churches in communities' mobilization and recruitment for NHIF membership. NHIF has introduced new packages for members for surgery, dialysis and cancer treatment.

The strategic partnership established with Kabarak University has provided a great opportunity for infrastructure and equipment improvement in CHAK member hospitals and expansion of medical education.

The planning and funding mobilization for the project is at an advanced stage and implementation of the first project phase will commence in 2017.

The USAID funded Afya Jijini project has given CHAK opportunity to serve the communities in Nairobi county in an integrated health and HIV project which is led by our faith based partner IMA WorldHealth.

CHAK Medical Equipment Programme continues to provide responsive technical support and maintenance services to faith based health facilities across Kenya.

MHUs needs for quality medicines and other essential medical supplies are effectively served by the world-class pharmaceutical supply chain organizations, MEDS which is a product of the successful ecumenical partnership between KCCB and CHAK. MEDS celebrated 30 years of growth and great service in 2016. We give all Glory to God!

Governance of CHAK

CHAK Constitution promotes democracy, transparency, and opportunity for participation by members.

CHAK Executive Committee (EXCO)

According to the Association's Constitution, CHAK officials and EXCO members are elected to serve a two-year term with a maximum of three terms.

The AGM held on April 28, 2016, conducted transparent and democratic elections for the position of vice-chair and chair for Western/North Rift Region and Eastrern/North Eastern Region.

Dr Mary Muchendu was re-elected vice-chair for a second term. Dr Oliver Mamati, Friends Lugulu Hospital Director was elected new chair for Western/North Rift Region while Mrs Mary Gitari was re-elected chair for the Eastern/North Eastern region for another term.

At the AGM in 2017, elections will be held for the Chairman, Treasurer and Vice-treasurer as well as chairs for Nyanza/South Rift and Central/Nairobi/South East/Coast Region who will have completed their two-year term. All are available and willing to continue serving should the AGM give them another opportunity.

The complete list of EXCO members who served in 2016 was as follows:

- Rev. Dr Robert Lang'at - Chairman
- Dr. Mary Muchendu - Vice-Chairman
- Mr. Wiliiam Shimanyula - Treasurer
- Ms. Christine Kimotho - Vice-Treasurer
- Mr. James Maina - RCC Chairman Central/ Nairobi/South East/Coast
- Dr. Oliver Mamati - RCC Chairman Western/ North Rift
- Mrs. Mary Gitari - RCC Chairman Eastern/North Eastern
- Mr. Samuel Maati - RCC Chairman Nyanza/ South Rift

EXCO held four meetings during the year, two of which were retreats. Through these meetings, they engaged in the formulation of policies, review and approval of projects and budgets. EXCO also had opportunity to receive and review programmatic and financial reports.

The Association's annual audit report and project specific audit reports were reviewed and approved. EXCO also dedicated time to address development of new initiatives and deal with challenges. EXCO provided leadership in the development of the vision, mission, values and strategic directions for the new strategic plan and approved the final strategic plan document and 3-Year Programme.

EXCO governance retreat for strategic plan development

EXCO held two retreats in the course of the year due to the critical transition of the strategic plan. The first retreat held in July in Elmentaita discussed the environmental context and went through strategic visioning facilitated by Mr Ochieng Oloo a consultant from CORAT Africa.

The retreat output was a new vision, mission, values and strategic goals. These were used by management and secretariat technical staff to develop the draft Strategic Plan 2017 – 2022.

The second retreat was held in Nyahururu which reviewed the end-term external evaluation report of the Strategic Plan 2011 – 2016 presented by the evaluation consultants and reviewed the draft Strategic Plan 2017–2022, draft M&E plan for the strategy and Communication Strategy.

It also discussed the National Doctor's Strike crisis and agreed on an advocacy action plan.

EXCO was assisted to process financial matters by the Finance Committee, which met quarterly and presented it's reports to EXCO. Members who served in the Finance Committee were:

- Mr. William Shimanyula - Chairman/Treasurer
- Dr. Mary Muchendu - Member
- Ms. Christine Kimotho - Member
- Mr. Jacob Onyango - Member
- Dr. Samuel Mwenda - General Secretary
- Mr. John Nzomo - Finance & Administration Manager
- Mr. Cornelius Ininda - Internal Auditor

CHAK Trustees

CHAK assets are held in trust by a team of trustees made up of senior church leaders of integrity and national stature. The complete list of CHAK trustees who served during the year is as follows:

- Rev. Dr. Robert Lang'at – Africa Gospel Church (AGC)
- Rt. Rev. Michael Sande - Anglican Church of Kenya (ACK)
- Rt. Rev. Joseph Wasonga – Anglican Church of Kenya (ACK)
- Rev. Prof. Zablon Nthamburi – Methodist Church in Kenya (MCK)
- Very Rev. Dr George Wanjau – Presbyterian Church of East Africa (PCEA)
- Rev. Joseph Maswai – Africa Inland Church (AIC)
- Pastor Jonathan Maangi – Seventh Day Adventist Church (SDA)
- Dr Samuel Mwenda – General Secretary (Ex-Officio)

CHAK Trustees from right: Chairman Rev. Dr. Robert Lang'at, Very Rev. Dr. George Wanjau, Pastor Jonathan Maangi, General Secretary Dr Samuel Mwenda, Rt. Rev. Michael Sande and Rev. Joseph Maswai.

Three of the CHAK Trustees also serve as Trustees of MEDS. The current CHAK representatives on MEDS Board of Trustees are:

- Rt. Rev. Michael Sande
- Rt. Rev. Joseph Wasonga
- Rev. Prof. Zablon Nthamburi

The Rev. Dr Robert Lang'at will replace Prof Nthamburi in the MEDS Board of Trustees in 2017 and will assume chairmanship of MEDS from June 2017.

CHAK Trustees were available and active during the year in supporting ecumenical partnerships and advocacy activities. They held their annual meeting in which they received the CHAK annual programmatic performance report, assets status report, update on donor funding partnerships, end-term evaluation recommendations and CHAK Strategic Plan 2017-2022. CHAK Guest House business performance report and updates on statutory compliance and legal matters were also presented and discussed.

CHAK Guest House and Conference Centre

CHAK Guest House was well maintained through out the year and provided good quality hospitality services that are competitive among similar hospitality facilities in Nairobi.

The Guest House provides convenient conferencing facilities to CHAK projects and programmes and assists CHAK in financing the administrative costs of security, water, electricity and internet services. The conference facilities were improved through installation of sound system and ceiling mounted LCD projection system and screens.

In 2016, the Guest House business operations did well. The gross revenue increased from Ksh30.6 million in 2015 to Ksh38.8 million at the close of 2016, representing an increase of 28 per cent.

Similarly the net profit for the year increased from a loss of about Ksh1.0 million in 2015 to close the year with a profit of Ksh3.9 million in 2016. The

good results were as a result of a stable business environment and increased business volume due to enhanced marketing strategies.

The Guest House Management Committee (GHMC) assists EXCO in steering the Guesthouse operations. The members of the GHMC who served in 2016 were:

- Ms. Christine Kimotho – Chairperson
- Mr. James Gituanja – Member
- Mrs. Jane Kathurima – Member
- Dr. Samuel Mwenda – General Secretary
- Mr. Patrick Kundu – Institution and Organization Development Manager
- Mr. John Nzomo – Finance & Administration Manager
- Mrs. Grace Koki Nthakyo – Guest House Manager (Secretary)

Regional Coordinating Committees (RCCs)

CHAK national network of membership is divided into four geographic regions namely:

i. Eastern/North Eastern – Chair is Mrs Mary Gitari from Maua Methodist Hospital, Meru County.
ii. Central, Nairobi, South East & Coast – Chair is Mr James Maina from KAG Health Ministries, Nairobi County.
iii. Western/ North Rift – Chair is Dr Oliver Mamati from Friends Lugulu Hospital, Bungoma County.
iv. Nyanza/ South Rift – Chair is Mr Samuel Maati from SDA Eronge, Nyamira County

Each region is coordinated by a Regional Coordinating Committee which meets at least three times a year. The Chairpersons of the RCCs are members of EXCO.

All the RCCs held the scheduled meetings in 2016. CHAK secretariat provided administrative support to the meetings and was represented at all the RCC meetings. RCCs have provided a rich forum for networking of MHUs at regional level, dissemination of information from the Secretariat and for receiving feedback from the members on advocacy issues that require joint action or CHAK Secretariat support.

The RCCs were actively involved in organizing meetings between CHAK members and the County Health Departments.

We appreciate MHUs and religious leaders who have been proactive in engaging county leadership on matters of strengthening partnership in health service delivery. The high number of counties (47) presents a major challenge for CHAK Secretariat regular participation in these meetings but effort will continue to be made to facilitate the county engagements where possible.

We encourage member health facilities and churches to proactively engage county governments at every opportunity due to the critical role they play in health services management at the county level. The Institutional & Organizational Development Department coordinates and facilitates the activities of the RCCs and will continue to support further engagement in the devolved County Government level. CHAK will also continue to leverage the ongoing project activities in the counties to facilitate county engagement at every available opportunity in order to strengthen partnership and gain support.

New CHAK Strategic Plan 2017 - 2022

The external evaluation of CHAK Strategic Plan 2011-2016 conducted by a consultancy team led by Prof. Dan Kaseje has documented the organisation's performance in the ended strategic plan period and identified organizational strengths and environmental opportunities which we need to build on.

It has however also pointed out our internal capacity gaps and external threats that will have to be addressed. Financing, staff retention, regulatory burden and sustainability of quality services have been identified as the key challenges facing MHUs in health service delivery.

The devolution of health services had an impact on the loss of some of the previous gains in recognition and support made in advocacy.

Developments in the health service delivery infrastructure and equipment in the counties and health workers recruitment has increased competition for clients and health workers.

CHAK Strategic Plan 2017–2022 whose theme is *"promoting universal access to quality health care in the devolved county health system in Kenya"* has been developed through a participatory process that involved member health units, EXCO and all secretariat departments and technical

staff. The Strategic Plan has the vision *"Quality Healthcare for all to the glory of God"*

To achieve this vision, CHAK Secretariat will be guided by the mission *"To facilitate provision of quality health services through health systems strengthening, innovative health programs, training, advocacy and partnerships as a witness to the healing ministry of Christ"*

The new Strategic Plan 2017-2022 will guide CHAK organization growth and provide strategic guidance for the CHAK network as it engages in the Global Health Agenda defined in the Sustainable Development Goals (SDGs), Kenya Vision 2030 and Health Policy Framework. The HPF promotes Universal Health Coverage (UHC) for both communicable and non-communicable diseases as well as reproductive, maternal, neonatal, child and adolescent health.

CHAK will scale up resource mobilization and partnerships for sustainable health systems strengthening and capacity building towards enhanced quality health care in the devolved health system in Kenya.

CHAK regional structure will be strengthened at the Regional Coordinating Committees (RCCs) to create effective County Engagement Structures (CES) to coordinate members' engagement with the county government health system. We shall advocate to get the MoU partnership framework that was developed between the Faith Based Health Services and Ministry of Health in 2009, re-negotiated to include the County Governments and Council of Governors so as to be well aligned with the current Kenya Constitution.

To maximize efficiency in utilization of the available scarce resources, CHAK has adopted a strategy of integration and partnerships.

The strategic plan priority areas have been clustered into five strategic directions namely:

- Health service delivery
- Health systems strengthening
- Capacity building and research
- Advocacy and partnerships
- Sustainable financing and resource management

The scope of health services will be expanded to include communicable, non-communicable, maternal and child health, nutrition and environmental health mental health and medical education and research.

In order to address our capacity gap in business development through proposal writing and the M&E weakness identified in the evaluation, the organizational structure has been enhanced to include a Business Development Unit and M&E and Information Management Unit.

Grant management capacity and internal control systems strengthening has been addressed by introducing an Internal Audit and Compliance Unit.

During the implementation of this plan, CHAK will scale up use of modern technology to enhance efficiency and evidence-based management of MHUs.

The integrated CHAK Hospital Management software implementation will be scaled up to more MHUs while promoting use of electronic medical records and timely reporting to the MOH through the established reporting tools and system (DHIS2).

We are rolling out this ambitious plan because we have inspiration from our Christian foundation. We trust God for the provision of partners, resources and an enabling environment.

Advocacy and partnerships

CHAK has a mandate for advocacy towards promoting access to quality health care. CHAK advocacy is mainly targeted towards enabling policy environment, health systems strengthening, access to essential health commodities and resources for health.

Our network presence in remote rural areas and slums of the cities also gives us the obligation to advocate for the poor and vulnerable towards improved access to affordable quality health services.

CHAK engages two main approaches to advocacy: one is proactive participation and engagement in dialogue on policy and planning and the second is building partnerships for a stronger voice and resources mobilization.

We value partnerships with other like-minded stakeholders in health because we believe that in walking together, we shall get further and will encourage and strengthen each other.

As part of this strategy CHAK plays an active

membership role in various inter-agency coordinating committees and technical working groups of the health sector, the Church Health Services Coordinating Committee and broader Faith based Health Services Coordinating Committee, Health NGOs Network (HENNET), Public-Private-Partnership for Health in Kenya, Ministerial Stakeholders Forum, the Global Fund KCM and PEPFAR-CSO Leadership Team.

We also take advantage of our leadership role in the Africa Christian Health Association's Platform (ACHAP) to create visibility for church health work in Africa at continental and international fora.

Our membership and partnership with World Council of Churches (WCC) Health and Healing Programme based in Geneva and Christian Connections for International Health (CCIH) of Washington DC has provided CHAK with a good platform for advocacy and visibility at the global level.

Our General Secretary has been invited through these relationships to strategic international events in Washington DC and Geneva to make presentations about church health services in Africa with CHAK as a successful model.

Partnership with NHIF

NHIF has become the key Government institution with mandate towards delivering universal health coverage for all Kenyans. CHAK has nurtured partnership with NHIF through regular consultation and feedback.

All CHAK hospitals and most health centres are accredited to NHIF for the provision of a range of medical benefit packages.

CHAK is an active member of the NHIF-FBO/ Private Sector Forum and is represented in its meetings by a team that includes secretariat and MHUs.

The meetings were fruitful in engaging on the new benefits packages. CHAK also hosted a meeting of member hospitals and health centres with NHIF and facilitated the hosting of a broader FBO meeting that engaged with NHIF top leadership.

The NHIF expanded benefits package includes:

- Maternity delivery package has been enhanced to Ksh10,000. For Caeserian Section the package has been enhanced to Ksh30,000.
- Dialysis support of Ksh8,000 per session for two sessions each week
- Daily in-patient rebates for FBO Hospitals have been enhanced from a range of Ksh1,600 – 2,200 to a range of Ksh2,500 – Ksh3,500 per day depending on hospital facilities and capacity.
- Surgical cover that includes minor surgery – Ksh 30,000 – 40,000, major surgery – Ksh 80,000 – 130,000, specialized surgery – Ksh 500,000.
- CT Scan – Ksh8,000 and MRI scan – Ksh16,000
- Rehabilitation services – Ksh60,000 per year
- Cancer treatment services
- In addition, NHIF will implement the new Government Linda Mama Free Maternity Services programme for all pregnant mothers that will be provided in FBO health facilities, county health facilities and interested private health facilities.

  Normal deliveries will be paid Ksh3,500 in health centres and Ksh6,000 in hospitals while Caesarian Sections will be paid Ksh17,000.

  Mothers have the convenience of enrolling through NHIF county offices, Huduma Centres, health facilities or through mobile phones.

  Future phases of Linda Mama will include antenatal and postnatal care and cover the mother, child and family.

CHAK welcomes with appreciation the improved benefits package and compensation to providers and will continue advocating for the review of out-patient capitation rates which are very low. Advocacy will also be done for introduction of benefits packages for chronic diseases such as hypertension and diabetes as well as laboratory investigations.

CHAK will also monitor the impact on service provision by MHUs to facilitate evidence based feedback, advocacy and continued partnership with NHIF.

CHAK General Secretary presented with Christian International Health Champion Award

The General Secretary, Dr Samuel Mwenda was presented with the third Christian International Health Champion Award which was announced by the Christian Connections for International Health (CCIH) Board at the CCIH Annual Conference. The event was held from June 17 – 19, 2016, at the Johns Hopkins University in Baltimore USA with the theme "Sustainable Development from a Christian Perspective".

The announcement and presentation was done on Sunday June 19, 2016, through Prof Henry Mosley who was the second recipient of the award in 2015.

This was the third award since it was launched in 2014 and the first to be given outside the USA. This award was in recognition of Dr Mwenda's dedication and leadership in the church health ministry and development of the ecumenical health movement in Africa.

We congratulate the GS for this award and thank God for the partners who acknowledge and support us in this important church ministry.

Dr Samuel Mwenda is presented with the Christian International Health Champion Award by Prof Henry Mosley on June 19, 2016 at the CCIH Conference held at the Johns Hopkins University, Baltimore USA.

Religious leaders support advocacy and dialogue during national health sector crisis

CHAK hosted a meeting for religious leaders from the diverse denominations of Protestant Churches who sponsor church health facilities and Medical Training Colleges in Kenya on February 9, 2017, at CHAK Guest House in Nairobi.

The meeting reviewed the crisis affecting the health sector in Kenya following the prolonged doctors' strike. The Forum discussed the impact of the crisis on the population and specifically to FBO health facilities which were maintaining service delivery with excessive work load and over-stretched resources.

An advocacy statement was adopted which addressed immediate critical challenges caused by the doctors' strike, and made appeal for short term support and long-term partnership framework with the national and county governments to support sustainability of Faith Based Health Services.

The decision to seek appointment with State House, MOH and Council of Governors was immediately pursued by the Chairman.

CHAK facilitated the convening of a meeting between religious leaders and the Cabinet Secretary-MOH on February 14, 2017, at Afya House, the Ministry of Health Headquarters. The meeting discussed the impact of the health sector crisis on FBO health facilities and requested for government support.

The religious leaders also offered their support in the mediation between the Government and doctors' union. Another meeting was hosted by NCCK on February 15 for the Inter-faith Religious Leaders which also discussed the doctors' strike and offered to provide a team of mediators to the negotiation process.

The stand-off was eventually resolved and strike called off following mediation process led by religious leaders.

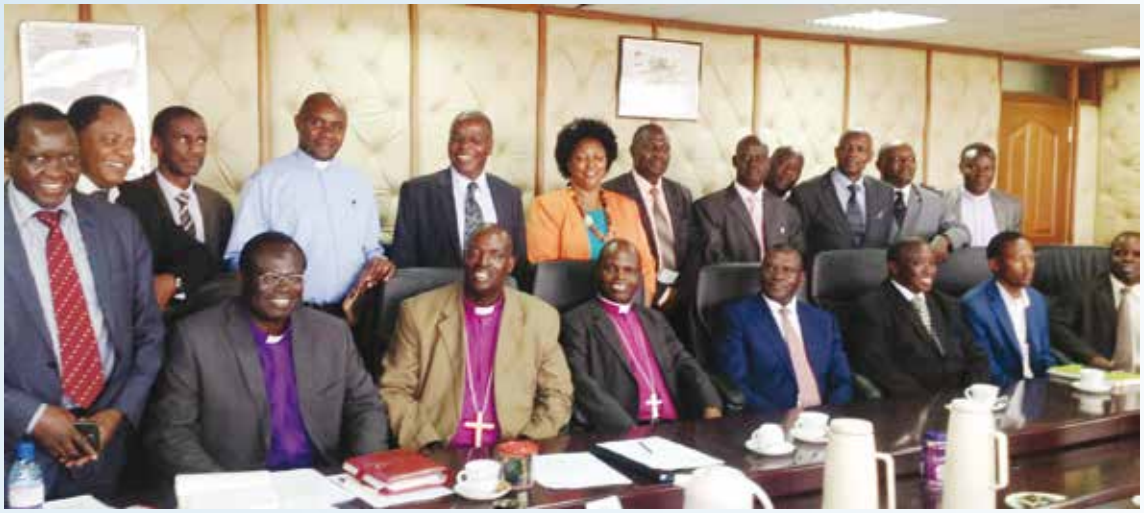
The religious leaders requested that the mutual collaboration that has existed between MOH and Faith Based Health Services be further re-defined by updating the MoU of 2009 to re-align it with the reality of the current Constitution of Kenya and the Devolved System of Government.

They also offered to initiate dialogue through a joint team involving faith based organizations, Ministry of Health and Council of Governors, to develop a partnership framework to guide recognition, inclusion, support, reporting and accountability.

This will create a structured and sustainable framework for partnership, support and mutual accountability at the two levels of Government.

The CS-MOH has written a letter thanking CHAK for its role towards ending the industrial stalemate.

We wish to acknowledge and deeply appreciate health care workers in Faith Based Health facilities who remained faithful and deeply committed to their calling of providing quality health services despite the overwhelming workload and overstretched resources.



Religious leaders and CHAK General Secretary Dr Mwenda with the CS-MOH Dr Cleopa Mailu at the meeting held at the Afya House board room to discuss the impact of the doctors' strike on faith based health services.

Mission For Essential Drugs and Supplies (MEDS)

The Mission for Essential Drugs and Supplies (MEDS) is a joint trust of CHAK and Kenya Conference of Catholic Bishops (KCCB) that provides high quality services in pharmaceutical supply chain, training and medicines quality assurance.

The ultra-modern MEDS Centre has provided state-of-the-art facilities for pharmaceutical warehousing and supply chain logistics that is serving faith based health facilities, charitable NGOs, county government health facilities and some of the referral MOH health facilities.

MEDS pharmaceutical and laboratory quality analysis services also cross the boarders of Kenya to serve some faith based and charitable NGO health services in other countries of Africa.

MEDS was established in 1986 and celebrated a major developmental milestone as it marked its 30th anniversary in 2016.

MEDS quality analysis laboratory is WHO-pre-qualified, giving it international recognition. This status has attracted business from within Kenya and other countries. MEDS ISO 9001:2008 certification has created a quality standard in all its operations and a system of continuous quality improvement.

CHAK strongly urges MHUs to ensure that they utilize MEDS pharmaceutical services for quality and affordable medicines and other medical supplies.

CHAK hosted a forum for MHUs in November which engaged MEDS on their services and sought ways of increasing utilization of MEDS services. This engagement will further be continued at CHAK Annual Health Conference and Annual General Meeting.

MEDS business volume increased to Ksh2.9 billion from Ksh2.5 billion the previous year. This involved sale and distribution of a wide range of both stock and non-stock items of medicines and other non-pharmaceutical commodities.

The net assets increased to Ksh1.45 billion up from Ksh1.4 billion the previous year. The revolving drug fund has grown to Ksh360.6m and priority will continue to be given to growing this fund due to the increased capacity and business volume of MEDS pharmaceutical operations.

There was substantial increase in the volume of sales to county governments with some of the supplied medicines being donated to FBO health facilities. However, county business presents a risk due to delays in payment and MEDS has had to introduce stringent control and follow up measures.

MEDS Board chairmanship rotates between KCCB and CHAK every three years. CHAK Chairman will take over chairmanship of MEDS in June 2017 following the completion of the term by the current chairman, Rt. Rev. Paul Kariuki.

We wish to thank MEDS for their great supply chain services for past 30 years and commit to continue working closely as we continue to strengthen health systems in Kenya..

CHAK Pension Scheme

CHAK Pension Scheme was started in July 2014 following registration with RBA. It is a contributory scheme to which the employer contributes 24 per cent and employees 6 per cent of basic salary monthly.

The second external audit was conducted by Mazars for the period ended December 31, 2016, and the returns filed as per RBA regulations.

The scheme has attained total fund value of Ksh70.9m having recorded investment income of Ksh5.7m in 2016.

The trustees that served during the year were:
- Jacob Onyango
- James Maina
- Dr Samuel Mwenda
- Ruth Kagure
- Grace Koki
- Gideon Ochiel

The scheme service providers are:
- Liberty Pension Services Ltd – Fund administrator
- CFC Stanbic Bank – Fund custodian
- Co-op Trust Investment Services Ltd– Fund manager
- Mazaars CPAK - Auditors

The trustees held quarterly meetings as required by RBA regulations to monitor regulatory compliance and fund performance.

The scheme is currently providing retirement benefit services for CHAK Secretariat staff but eventually will open up to receive membership from interested MHUs, provided they commit to abide by the scheme trust deed rules and regulations. CHAK vision for this fund is to provide dependable retirement security for all its staff as part of staff welfare and retention strategy.

CHAK field offices

As a result of our success in the mobilization of resources in support of health programmes in various parts of the country, CHAK has opened offices in Vihiga and Nyamira counties which are hosted by MHUs.

The new CDC-funded CHAP-Uzima project will expand CHAK regional offices to Machakos, Nakuru (Naivasha) and Embu counties.

CHAK also continued to have regional presence through the APHIAPlus Kamili project with staff based in Thika (Kiambu) and Meru counties. These staff also support other CHAK health programmes implemented by MHUs.

CHAK medical equipment programme

CHAK Medical Equipment Programme provides a critical service of medical equipment installation, repair and maintenance.

Our highly experienced technical team has carved a niche in anaesthesia equipment maintenance and x-ray units repair, maintenance and radiation monitoring through accreditation by the Radiation Protection Board.

The team also maintains and repairs general medical equipment and plants. This essential support is available to CHAK members and other faith based health facilities as a priority before being extended to Government facilities and the private sector.

The Health Care Technical Services (HCTS) team also provides technical support for and facilitates procurement of medical equipment.

The HCTS services must be self-sustaining, hence a fee is charged for services which we believe is competitive and good value for money.

We wish to appreciate CHAK members who regularly utilize the HCTS services. We further appeal to all MHUs to utilize the services and make prompt payment for the work done for sustainability and growth of the programme.

We also appeal to MHUs with debts from services provided to settle their invoices as soon as possible.

Sustainability of CHAK technical services

CHAK has been extending technical support services in the areas of architectural designs and construction supervision, hospital management system and medical equipment maintenance.

Due to declined donor funding, CHAK has to find other strategies for financing these services.

Since these services are provided on demand by MHUs, EXCO has approved management recommendation to introduce service fees or cost sharing with the MHUs requesting these services.

The contribution and mode of payment will be discussed and agreed upon with the respective MHU management based on their requirements.

CHAK membership annual subscription

CHAK annual subscription for all categories of membership has not been reviewed since 2011. Moving forward, EXCO has approved review of the annual membership subscription to be implemented from January 2018 as follows:

Membership item	Current Fee (Ksh)	New Fee (Ksh)
Application fee	500	2,000
Annual Subscription fee for Hospitals level 5	15,000	20,000
Annual Subscription fee for Hospitals level 4	10,000	15,000
Annual Subscription fee for Health Centre	3,000	5,000
Annual Subscription fee for Dispensary	1,500	3,000
Annual Subscription fee for Churches	1,500	3,000
Annual Subscription fee for Medical Training College	1,500	3,000
Annual Subscription fee for Community Based Health Care (CBHC) Organizations	1,500	3,000

Review of annual membership subscription to be implemented from January 2018

CHAK assets and financial status in 2016

Net assets growth

The Association's net asset book value recorded a decrease of 1.23 per cent from Ksh207.5 million in 2015 to close at Ksh204.9 million in 2016.

There were no major capital or equipment purchased during the year and the decrease is attributable to depreciation charge for the year and a deficit of Ksh1.6m realized during the year on the consolidated operations.

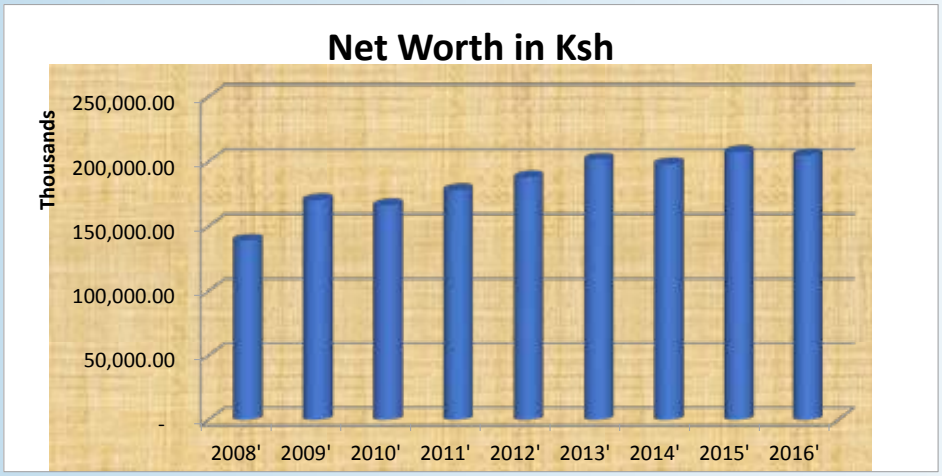
It is also worth noting that the land on which the CHAK offices stand has been fully amortized and value is expected to increase when renewal of the lease process is completed and revaluation done.

Total revenue

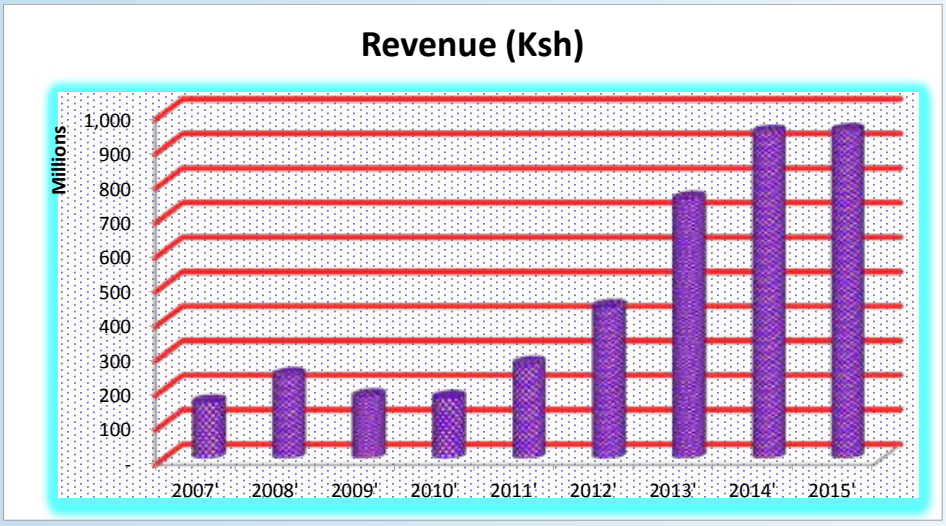
The Association's gross revenue increased from Ksh948.9 million in 2015 to close at Ksh953.2 million in 2016.

The good performance was as a result of increased funding to the CDC HIV project which contributed 65 per cent of total revenue. The other sources included Bread for the World from Germany-11 per cent, Global Fund projects - 4 per cent, CHAK Guesthouse and Conference Centre - 4 per cent, Healthy Heart Africa project funded by Astra Zeneca - 5 per cent, USAID-funded HIV and family planning projects - 6 per cent and others -5 per cent. The table below shows contributions by funding category.

CHAK is grateful to the donor partners who continue to entrust us with their resources and wish to assure them of our commitment to full compliance with their requirements and delivery on the agreed performance indicators.



Net asset book value 2008-2016



CHAK revenue growth over the last nine years

CHAK – Kabarak University partnership

CHAK has developed a strategic partnership with Kabarak University. The partnership is motivated by shared Christian values and mutual interest in developing high quality Christian health services with a functional referral network and expansion of medical education.

Kabarak University has established a medical school with nursing, clinical medicine, laboratory sciences and pharmacy undergraduate programmes as well as the Family Medicine post graduate programme.

The Family Medicine residency training programme was launched in September 2015 and continued to grow with the second intake of six registrars in 2016. The training programme is being delivered in partnership with AIC Kijabe, Tenwek and PCEA Chogoria hospitals.

KABU School of Medicine was facilitated by CHAK to visit other member hospitals with potential for running the programme. These were Maua Methodist Hospital, AIC Litein Hospital, AIC Kapsowar Hospital and PCEA Tumutumu Hospital.

A scholarship fund operated through INFAMED provided scholarships to all the registrars in training. We encourage doctors in CHAK member hospitals to take advantage of this opportunity to join the Family Medicine programme during the 2017 intake.

KABU Medical School has interest in partnering with several CHAK hospitals in clinical placements and other nursing and medical programmes.

Kabarak University made good progress in planning and mobilization of resources to support infrastructure development in order to facilitate expansion of quality health services, medical education and research at the Kabarak Teaching, Referral and Research Mission Hospital (KTRRMH) and 23 CHAK member hospitals through the Kenya Mission Hospitals Improvement Project (KeMHIP).

Plans are underway for the official launch and ground breaking ceremony of the first phase of the project to be held in June 2017.

We thank HE Retired President Moi, the chancellor of Kabarak University for his great vision and for the generosity that he has extended to mission hospitals through this project.

CHAK-CDC/PEPFAR partnership in new HIV&AIDS project

CHAP Uzima is a CD- funded five year follow on project to the CHAK HIV/AIDS Project (CHAP) that ended on March 31, 2017.

The new award commenced on April 1, 2017, and will run until March 31, 2022. The first year approved budget is USD7.7 million. The project consortium partners are MEDS, University of Nairobi and Palladium.

The previous CHAK HIV/AIDS Project predominantly supported HIV prevention and treatment services to about 43,000 PLHIV in 54 faith based health facilities in 18 counties.

CHAP Uzima will support an increased scope of services that includes HIV care and treatment services to over 46,000 PLWHIV, including 1,500 from Narok County, Orphans and Vulnerable Children (OVC) services for 6,000 orphans and 1,000 households in Machakos, Kajiado, Narok and Nairobi counties supported through Africa Brotherhood Church (ABC), Adventist Centre for Care and Support (ACCS), Anglican Development Services (ACKNIDP), and Apostles of Jesus AIDS Ministries (AJAM). Gender Based Violence (GBV) services will be integrated into all supported health facilities.

Our commitment is to deliver quality compassionate care, while ensuring efficient stewardship of the donor resources through effective partnerships. We thank our donor, CDC/ PEPFAR, for confidence in CHAK and for the opportunity to collaborate in yet another major project.

Development partners

Bread for the World-Church Development Services (BfdW)

CHAK is highly indebted to Bread for the World-Church Development Services (BfdW) for the long term partnership and most generous support.

Indeed, BfdW has been a dependable long-term development partner who supported the core budget for the three-year programe of the Revised CHAK Strategic Plan 2011-2016 including the end-term evaluation process.

CHAK has signed another three-year funding contract with BfdW to provide 50 per cent support towards implementation the first three-year programme (phase one) of the new Strategic Plan 2017-2022. The support provides CHAK with the necessary organizational structure, capacity and systems to engage in strategic plan implementation, advocacy, capacity building, service delivery and additional resource mobilization towards delivering the other components in our strategic plan.

Global Fund to Fight TB, HIV/AIDS and Malaria (GFTAM)

This continued to be an important source of funding for CHAK health programmes targeting TB and Malaria. CHAK received funding under the Global Fund New Funding Model through AMREF for TB active case finding and defaulter tracing in Nyamira and Machakos counties and Malaria community management in Vihiga County.

USG PEPFAR funding

- CDC-CHAK completed the five-year CHAK HIV&AIDS Program (CHAP) which aimed to scale up quality HIV care and treatment in faith based health facilities in Eastern, Central, Nairobi and Coast regions. Year five was extended by six months to March 31, 2017, with total funding of USD 8.2m.
- USAID–APHIAPlus Kamili project led by JPHIEGO was extended by one year and the scope reduced to HIV prevention, care and treatment in faith based health facilities in Eastern and Central regions of Kenya. The CHAK supported sites were reduced to 23.
- USAID-Afya Jijini project is implemented by the IMA WorldHealth-led consortium to which CHAK is a member. The project completed its first year and started the second year. The CHAK team supports HIV prevention, care and treatment services, maternal and child health services, nutrition and WASH.

  CHAK's scope covers the two sub-counties of Westlands and Kamukunji. Despite the funding mechanism being a contract, the CHAK team did well in delivering the project targets.

Packard Foundation

The new two-year grant by the Packard Foundation of USA went through the first year of implementation. The project is implemented in Kenya and Uganda through Uganda Protestant Medical Bureau (UPMB). The project supports capacity building, community mobilization, engagement with religious leaders and service delivery to scale up quality family planning services.

The Open Society Institute

The private foundation from USA has continued to support a legal officer to spearhead capacity building, advocacy and technical support activities directed at promoting the legal and human rights of people living with HIV&AIDS.

The project supported activities in 17 MHUs. The project has provided hope and created impact in mitigating HIV-related stigma and discrimination through empowerment and legal accompaniment.

During the new two-year phase the project will focus on integrating human rights to existing health services.

Novo Nordisk and DANIDA

CHAK continued to receive funding and technical support from Novo Nordisk and DANIDA for building capacity and scaling up quality diabetes management in FBO health facilities.

Training of health workers was scaled up through hospital-based mentorship using mentors already trained in facilitation.

CHAK is grateful to Novo Nordisk, DANIDA, MOH and other project partners for this important initiative that is addressing a non-communicable disease that has become an increasing burden to our people and health facilities.

The success of this public-private-partnership has attracted other partners particularly to support blood sugar screening and diabetes control monitoring. We wish to thank Roche for committing to provide an additional donation

of 750 glucometers which will be distributed through MHUs to people living with diabetes and Community Health Workers promoting diabetes prevention education and screening

AstraZeneca

CHAK is implementing the Healthy Heart Africa project to address the burden of Hypertension in Kenya through funding from AstraZeneca.

The project supports education and awareness on hypertension risk factors and management, provides blood pressure screening at community level, facilitates linkages for referral to health facilities for hypertension management and provides quality essential hypertension medicines through MEDS at a highly subsidized and affordable price.

Among the five partners implementing this project, CHAK has a unique implementation model that involves health facility–Church–Community linkages.

The pilot project was completed and AstraZeneca awarded CHAK a three-year project. The project's focus is identification of people with hypertension and linking them to health facilities for quality treatment to ensure their blood pressure is controlled.

CHAK is pleased to continue with this project that seeks to address a major non-communicable health problem in Kenya and for the opportunity to facilitate joint health action between health facilities, churches and communities. This is our unique strength.

Gates Foundation/CCIH

CHAK is a member of Christian Connections for International Health (CCIH) of USA and has been partnering with CCIH in advocacy for increased investment in maternal and child health programmes.

CHAK is an implementing partner for a family planning advocacy project which is funded by the Bill & Melinda Gates Foundation through CCIH.

The project is supporting capacity building of religious leaders and health workers in advocacy and supporting advocacy at county, national, regional and international level. This is aimed at increasing focus and investment in maternal health and family planning.

It also facilitates media engagement on maternal health.

The other partners in the project are Churches Health Association of Zambia (CHAZ) and Ecumenical Pharmaceutical Network (EPN).

Micronutrient Initiative

This is a two-year nutrition project funded by Micronutrient Initiative from Cananda. The project involves capacity building on good nutrition. Support provided will be in the form of nutritional supplements such as folate and iron.

The project will train and engage health workers, religious leaders and community health volunteers for nutrition awareness and distribution of these nutritional supplements.

World Diabetic Foundation

The AFORD Kenya Project is a two-year initiative that is funded by the World Diabetic Foundation. The project targets community education, mobilization and screening for diabetes prevention and control.

The project will provide 700 units of blood sugar testing glucometers that will be used for diabetes screening at the community level.

CHAK will implement the project with MHUs in Nyamira, Kisii and Kericho Counties.

Novartis

The Novartis NCDs project is a two-year initiative which involves capacity building of health workers and community health workers and access to high quality medicines for diabetes, hypertension, asthma and breast cancer at a highly subsidized price. The medicines will be supplied through MEDS.

Solarchill

The Solarchill project is supported by the Global Environment Facility (GEF) to promote affordable, autonomous and battery free solar cooling equipment for both medical and commercial applications.

The project is coordinated and carried out by the SolarChill Consortium which includes SKAT Foundation, UNEP, UNICEF, GIZ, GmbH, Greenpeace International, Danish Technological Institute, HEAT GmbH and PATH that will work in close cooperation with the participating countries of Kenya, Swaziland and Colombia from June 2016 to December 2018.

CHAK was selected to collaborate with the SolarcChill Consortium in the implementation of

the project and distribution of the solar fridges in Kenya. There will be capacity building of the Kenyan technical workforce on the installation and maintenance requirements of SollarChill units and technology transfer for local manufacturing of the units.

Conclusion

We thank all our partners for holding hands with us in 2016 and invite their continued partnership and support as we get into the implementation of our new Strategic Plan 2017-2022.

We thank God Almighty for His faithfulness in providing for the healing ministry at CHAK. The people God has provided to work with us have been a blessing.

We thank all health workers in faith-based health facilities for their compassion, dedication and resilience even during times of crisis and intense pressure.

CHAK has received generous funding support and has been able to attract new partnerships and commitments for extension of partnerships through new projects that will continue in 2017.

I wish to thank the Trustees, EXCO, management, staff, partners and members for their prayers, commitment, hard work and dedication to the mission of CHAK.

The achievements accomplished in 2016 have been due to our collective effort. Let us keep up the good work.

Hebrew 6:10 "God is not unjust; he will not forget your work and the love you have shown Him as you have helped His people"

2 Chronicles 15:7 "…Be strong and do not give up for your work will be rewarded"

May God bless you all. To God be all the glory!

Rev. Dr. Robert Lang'at, CHAIRMAN

General Secretary's Report

CHAK Strategic Plan 2011-2016 end-term evaluation

CHAK Strategic Plan 2011 – 2016 end term evaluation was conducted by a team of consultants led by Prof. Dan Kaseje from the Tropical Institute of Community Health in Africa (TICH-Africa). The evaluation covered the two phases of the three-year implementation programmes - 2011-2013 and 2014-2016.

The evaluation noted that during the strategic plan period 2011-2016, CHAK focused on promoting access to quality health care by facilitating all member health units (MHUs) to provide efficient, equitable, affordable, sustainable and high quality health care as a witness to the healing ministry of Christ.

The work was organized around nine strategic directions that fall into six broad categories: service delivery, health systems strengthening, governance and accountability, research, advocacy and communication, human resources for health (HRH) and health care financing and sustainability.

Key findings

The evaluation found that CHAK had maintained relevance through functions that members could only benefit from as an Association and not as individual units. These were advocacy, health systems strengthening, joint resource mobilization, networking, pooled experience and expertise.

CHAK had performed very well, and had met its obligations and exceeded targets in several areas leading to sustained growth in funding, asset base and program activities expansion.

However, well funded activities such as HIV, TB, malaria, hypertension and diabetes were better documented in regular reports. Other important service delivery areas such as maternal, neonatal and child health that had not benefitted from designated donor funding tended to suffer under-reporting, giving the erroneous impression of under-performance.

CHAK demonstrated efficiency in service delivery and achieved better results than other agencies in the health sector, due to commitment and community approach as a strategy for service delivery.

Community Health Strategy (MoH, 2006) provides an opportunity yet to be fully exploited to enable CHAK spearhead attainment of Universal Health Coverage and SDGs. Total quality management has taken root in CHAK and was ready for rapid scale up.

Working through RCCs had not achieved the targets as planned, at a time when they were needed to engage the devolved health system in addressing the concerns of MHUs.

The under-performance was due to assignment of tasks that could not be undertaken efficiently by a committee.

County engagement started in earnest, with varying responses from different counties that are themselves at different levels of development.

The CHAK information management software provides an opportunity to improve evidence based service delivery, advocacy and partnerships with counties and NHIF. However, the institutional M&E function was not optimally developed.

CHAK supported its governing structures: AGM, Trustees, EXCO and Finance Committee adequately in their functions to maintain sound systems and structure of leadership, transparency and accountability. External audits throughout the strategic plan period gave unqualified opinions, implying compliance with international standards in financial management.

Additionally, CHAK developed model governance and management policy documents to guide MHUs and ensure integrity and accountability.

Active strategic participation of CHAK at national level to influence health policy and service delivery was maintained with remarkable impact. The annual health conference, CHAK Times bulletin, resource centre, international networking

and an active website were effective communication mechanisms that CHAK maintained and utilized as envisioned. CHAK undertook some studies, but the use of results to support marketing, advocacy and partnership negotiations could be improved.

CHAK coordinated excellent capacity building programs (Internship for doctors, short courses, CME, Family Medicine). The major challenge in human resources was high staff turn-over which has increased in recent times affecting smaller member health units more, although CHAK was also able to negotiate for secondment of staff by counties.

There were indications of improvement in human resource (HR) management in a number of MHUs some of which had developed HR plans, policies, and even HR departments with qualified personnel and budgets. CHAK secretariat has a HR expert to sustain continuous improvement particularly in addressing problems of staff retention and regulatory compliance. CHAK had also developed and registered a staff retirement pension scheme in which all staff including those from MHUs staff are eligible for membership.

During the period under review CHAK demonstrated steady growth in service delivery activities, national image development and alignment of its relevance within the Kenyan health sector evolving reforms as well in the global arena. Furthermore, CHAK had developed and launched the now functioning Guesthouse and Conference Centre with potential for further growth.

All these factors provide strong pillars for a sustainable CHAK.

Key recommendations

There is urgent need to improve regular reporting of all planned activities by objective to support advocacy for national and county resources, taking advantage of CHAK HMIS software.

Developing a robust institutionalized M&E unit to provide overall technical leadership to all funded CHAK projects and routine health care services will go a long way to harmonize reporting to enable evidence based decisions, planning and implementation.

There is need to review the composition and mandate of RCCs, building on lessons from the success at national level. Composition could be expanded to include other FBOs, and County Government representatives, and mandate focused on convening regional collaborative and steering meetings for linkages, networking and joint advocacy for collective bargaining in their respective counties.

There is need to establish required minimal standards based on TQM framework to maintain CHAK membership, and towards this larger member facilities could adopt and mentor a number of smaller ones to accelerate achievement of these requirements. CHAK should prioritize strengthening FBO-NHIF partnership involving all health facilities towards sustainable Universal Health Coverage. CHAK should also engage member Medical Training Colleges and universities for partnership towards staff professional development and research.

CHAK should fast track adoption of a strategic business mind-set approach in developing and delivering services in an increasingly competitive market place that demands efficiency in the delivery of quality health care.

Emerging strategic directions

The evaluation has identified the following emerging strategic directions:

i. Leadership, governance, advocacy, partnerships and networking
ii. Human resource and capacity building
iii. Monitoring & evaluation, research, information and communication
iv. Financing, sustainability and grant management

New CHAK Strategic Plan 2017–2022 and three-year programme

The new CHAK Strategic Plan 2017-2022 which has been developed through a widely consultative process, will guide CHAK organization growth and provide strategic guidance for the CHAK network as it engages in the global health agenda. This agenda is defined in the Sustainable Development Goals (SDGs), the Kenya Vision 2030 and Health Policy Framework which promotes Universal Health Coverage (UHC) for both communicable and non-communicable diseases as well as Reproductive, Maternal, Neonatal, Child and Adolescent Health.

CHAK will scale up resource mobilization and partnerships for sustainable health systems strengthening and capacity building towards enhanced quality health care in the devolved health system in Kenya

The Strategic Plan 2017-2022 has the vision "Quality healthcare for all to the glory of God"
To achieve this vision, CHAK Secretariat will be guided by the mission "To facilitate provision of quality health services through health systems strengthening, innovative health programs, training, advocacy and partnerships as a witness to the healing ministry of Christ".

Strategic directions

The six-year plan has its core activities organized into five strategic directions:

1. Health service delivery
2. Health systems strengthening
3. Capacity building and research
4. Advocacy and partnerships
5. Sustainable financing and resource management

Strategic Direction 1: Health service delivery
Strategic priorities
1. Communicable Diseases
a. HIV&AIDS
b. Tuberculosis (TB)
c. Malaria
d. Neglected tropical diseases
i. Leishmaniasis
ii. Schistosomiasis
2. Non Communicable diseases
a. Hypertension
b. Diabetes
c. Breast Cancer
d. Bronchial Asthma
e. Health for the aged

3. Reproductive, maternal, neonatal and child health and family planning
a. MNCH
b. Family planning and reproductive health
c. Nutrition in MNCH
4. Environmental and nutrition health
5. Orphans and vulnerable children (OVCs)
6. Mental health
7. Visual impairment

Strategic Direction 2: Health Systems Strengthening
Strategic priorities
1. Institutional Organization Development
a. Infrastructure development
b. Governance and managenent capacity building
2. Regional structures strengthening
3. County engagement structures
4. Health care technical services
5. Human resources for health management
6. Health quality management systems

Strategic direction 3: Monitoring and evaluation, research and learning
Strategic priorities
1. Monitoring and evaluation
2. Research
3. Learning and capacity building
4. Medical education through teaching hospitals and member Medical Training Colleges (MTCs)
5. Communication and Documentation
6. Health Management Information Systems

Strategic Direction 4: Sustainable financing and resource management
Strategic priorities
1. Resource mobilization
2. Healthcare financing for Universal Health Coverage
3. Financial management
4. Audit and systems strengthening

5. Asset management
6. CHAK Guest House management

Strategic Direction 5: Advocacy, partnership and networking
Strategic priorities
1. Strategic partnerships for health
2. Advocacy for CHAK member health network
3. Networking for knowledge sharing
• Strategic Plan 2017 – 2022
• Three-year programme 2017 – 2019
• M&E plan for the strategic plan
• Communication strategy for the plan

Strategic plan implementation

CHAK has developed an M&E Plan for the Strategic Plan which has defined indicators and targets that will be tracked quarterly, six monthly and annually.

A three-year programme covering the period January 2017 to December 2019 has been developed and budget co-funding commitment obtained with Bread for the World.

An annual workplan for 2017 has been developed that incorporates targets for projects and programmes. The workplan's implementation will be monitored on monthly and quarterly basis and reports compiled. Annual progress reviews will be undertaken by management and EXCO.

Resource mobilization will be scaled up through partnerships towards enhancing capacity for the strategic plan implementation. A Communication Strategy has been developed to guide communication and engagement of stakeholders.

A mid-term external evaluation will be conducted in 2019, and findings and recommendations utilized to further improve the strategy.

CHAK staff in group discussions at a retreat to develop the new strategic plan.

Faith-based organizations' dissemination forum on achievements in HIV response in Kenya

Five faith-based organisations came together on November 3, 2016, to celebrate and showcase their resounding success in the fight against HIV/AIDS in Kenya.

The five organisations – CHAK, Kenya Conference of Catholic Bishops (KCCB), Coptic Mission Hospital, Eastern Deanery Aids Relief Program (EDARP) and BOMU Medical Centre, have over the last five years been supported by CDC Kenya through the funding from the President's Emergency Plan for AIDS Relief (PEPFAR).

The event hosted in Nairobi in partnership with CDC was graced by the US Embassy Deputy Chief of Mission, CDC Kenya Country Director, PEPFAR Kenya Coordinator, NACC Director, Head of NASCOP, CECs for Health from 11 counties, USAID, other development partners, religious leaders, HIV stakeholders and implementing partners.

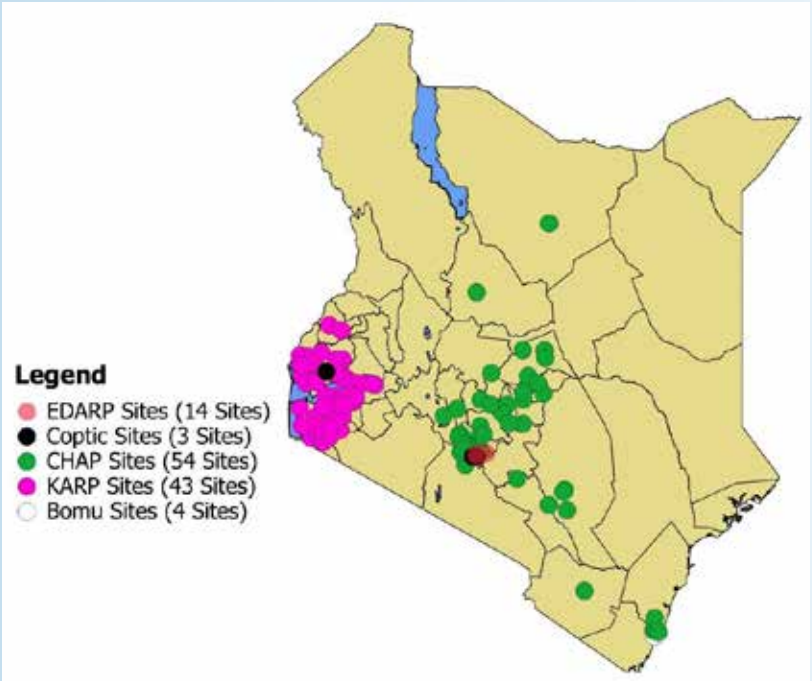
The US Deputy Chief of Mission underscored the importance of partnership with faith based organizations in the HIV response because of their foundation and commitment to compassionate quality services to the people including their network coverage to hard to reach areas. According to CDC Kenya Country Director Dr. Kevin M. De Cock, the five FBOs contributed to almost 30 per cent of the ART achievements for CDC and to 17 per cent of the national figures.

During the colourful and well attended forum, the FBOs also shared best practices in TB management and improving care and treatment of children and young people which were learned during implementation of their diverse projects. Testimonies of PLWHIV who had benefitted from the life-saving programmes implemented by the five faith based organisations formed the main highlight of the event.

Contribution of the faith-based organizations to the HIV response in Kenya

The Christian Health Association of Kenya (CHAK), Kenya Conference of Catholic Bishops (KCCB), Coptic Mission Hospital, Eastern Deanery Aids Relief Program (EDARP) and BOMU Medical Center, are networks of Protestant, Catholic, Orthodox and Muslim affiliated health facilities that are native to Kenya and have been providing preventive, promotive and curative health care services across all the 47 counties in the country.

With funding support from the US President's Emergency Plan for AIDS Relief (PEPFAR)



- **118 facilities**
- **26 counties**
- **17 per cent of national ART achievements**

through CDC, CHAK, KCCB, Coptic Mission Hospital, EDARP and BOMU have for over 10 years supported comprehensive HIV prevention, care and treatment services to over 100 health facilities in the country.

The five faith-based organizations have in the last five years managed a collective funding amount of over USD146 million through their respective cooperative agreements.

This has been through sound financial management practices in accordance with the United States Government grant compliance regulations.

Through these funds the faith-based organizations have supported care and treatment interventions to over 165,000 patients active on ART in 26 counties. In addition, they have contributed to the reduction of new HIV infections within priority populations which include adolescent girls, young women, and fisher folk among many others.

Together, the five FBOs have recorded key achievement which include:

- Over 2.5 million Kenyans got to know their HIV status over the past five years.
- Provided 165,000 patients with antiretroviral therapy (ART)
- The number of persons accessing HIV testing has increased four-fold between 2011 and 2016.
- Being on the right path to elimination of mother to child transmission of HIV - transmission rates of below 5 per cent for three consecutive years.
- 12-month retention maintained at above 90 per cent
- Overall viral suppression of 90 per cent
- Universal access to electronic medical records systems in all 118 facilities
- 40 facilities point of care (paperless) electronic medical records systems
- Six KENAS/ISO accredited laboratories
- One national sentinel site for pharmacovigilance.
- Three national HIV training centres
- Over 96 per cent TB screening uptake
- Reduced TB related mortality by 50 per cent
- Infrastructure support with clinical and laboratory equipment in all 118 health facilities

The five organizations have also worked in close collaboration with the National Government and County Health Management Teams to leverage resources for the faith-based and affiliated health facilities, aided in the capacity building of health care workers and strengthened health systems to improve HIV and TB outcomes.

Feedback and recommendations received from the forum participants would be used to further enhance the future HIV programmes.

We are very grateful that CDC and PEPFAR have awarded these faith based organizations follow-on grants to continue the great work. For CHAK, the new CHAP Uzima grant has expanded scope and coverage to include more FBO HIV treatment sites and OVC support.

Advocacy, partnerships & networking

CHAK Annual Health Conference and AGM 2016 and 70th Anniversary Celebrations

CHAK holds a national Faith Based Health Conference which is followed by the AGM business meeting. The conference creates an excellent opportunity for networking, sharing of experiences, partnership engagement, dissemination of performance reports and joint strategy consensus building for advocacy.

The CHAK Annual Health Conference and Annual General Meeting 2016 was successfully held on April 26 – 28, 2016, at AACC Desmond Tutu Conference Centre. The event was attended by over 260 delegates comprising CHAK member health unit representatives, development partners, Ministry of Health representatives and representatives from various counties. Also in attendance were representatives of health sector regulatory bodies, among others.

The conference provided opportunity for celebration with the CHAK network family of the 70th Anniversary since CHAK was established in 1946. The conference programme was structured to have plenary panel presentations and discussion, break-out workshops, medical exhibition and Worship sessions.

Annual Health Conference

The Annual Health Conference theme was "Partnerships for sustainable quality health care in the context of the new Global Sustainable Development Goals".

The conference was structured in plenary sessions and two technical workshops focusing on:

- Health Systems Strengthening and Community Systems
- Health service delivery – covering communicable and non-communicable diseases

Presentations focused on the role of partnerships in delivering quality health services in CHAK programmes and member health facilities.

The presentations were grounded on the United Nations Sustainable Development Goals that were launched in 2015 to act as a reference point for the international development agenda.

Key presentations focused on non-communicable diseases, including CHAK's contribution towards overcoming this health challenge in Kenya as well as Government action towards control and treatment of NCDs.

CHAK health facilities were encouraged to seek partnerships with County Governments in order to draw from the available resources through a presentation on Public-Private-Partnerships delivered by Dr William Muraah, CEC for Health, Meru County. AIC Kijabe Hospital encouraged other CHAK MHUs to mobilise resources through marketing and partnerships.

The Kenya Medical Laboratory Technicians and

Philemon Kimutai, the project's coordinator and key liaison for KABU makes a presentation at the CHAK Annual Health Conference 2016.

Technologists Board was on hand to sensitise the CHAK network on its role, licensing and other requirements for smooth laboratory operations.

PCEA Tumutumu Hospital and PCEA Chogoria Hospital shared on implementation of quality improvement and its effect on their operations while Kendu Adventist Hospital focused on its achievements and challenges in delivering HIV/AIDS services in a high prevalence zone.

In health care financing, AIC Litein Hospital provided a case study on how it had successfully utilised NHIF to improve patient numbers and revenue.

The conference also discussed the Kenya Mission Hospitals Improvement Project" (KeMHIP), a five-year project expected to be implemented in CHAK member facilities. The project is expected to accomplish the following outputs by completion.

1. Develop a 500-bed capacity high-end teaching and referral mission hospital in Kabarak together with all support facilities including housing for students and staff and research centre
2. Develop two satellite 250-bed hospitals in Eldoret and Nairobi
3. Expand, develop and improve infrastructure as well as equip 23 CHAK member hospitals
4. Develop or improve medical education facilities including faculty and student housing
5. Create functional and effective referral linkages between CHAK hospitals and Kabarak Teaching and Referral Mission Hospital
6. Build partnerships for medical education, clinical placements and research between CHAK hospitals and Kabarak Teaching and Referral Mission Hospital

Medical exhibition

An exhibition was held throughout the conference. CHAK HHA project, BoP project and partners provided free blood pressure and blood sugar screening to interested conference delegates throughout the conference. The exhibition also attracted partner organisations and member health facilities who sought to show case their work to conference delegates.

A celebratory cake was cut to mark CHAK's 70th anniversary during the AHC/AGM 2016.

Annual General Meeting

During the AGM held on April 28, Dr Mary Muchendu was re-elected CHAK vice chair while Mary Gitari was re-elected RCC chair for Eastern/North Eastern region. Dr Oliver Mamati, MOIC, Friends Lugulu Mission Hospital, was elected the new chair for Western/North Rift region to replace Samuel Jomo who retired on completing the maximum allowable term.

The AGM also approved a Constitutional amendment that provides for CHAK assets distribution only to MHUs which provide charitable health services in the event of its dissolution.

CHAK 70th anniversary celebrations

A dinner reception was held on Wednesday April 27, 2016, to celebrate CHAK 70th Anniversary and recognize retiring EXCO member, Samuel Jomo.

An informative and inspiring reflection on CHAK's journey of organizational development and the church health ministry in Kenya was given by Trustee, Rev. Dr George Wanjau.

Rev. Dr. Wanjau inspired and challenged those present to take the vision to greater heights by working towards expansion of specialized services and medical education.

CHAK Times released a special issue that was dedicated to CHAK 70th Anniversary which traced the journey of CHAK organizational growth from the perspective of various key stakeholders. It also show cased some of the successful CHAK projects and programmes.

Advocacy and representation in the health sector

One of the core mandates of CHAK is advocacy, partnership and representation of the Protestant Churches Health Services with Government, international organizations including UN agencies, development partners and private sector.

CHAK has evolved into a credible voice of the faith based health sector in Kenya and Africa. Through our approach of nurturing strategic partnerships, value based interactions and evidence based advocacy, CHAK has continued to grow its organizational image in the health sector.

Faith Based Health Services Coordinating Committee

At the national level, CHAK continued to play a key role in providing leadership to the Faith Based Health Services Coordinating Committee (FBHSCC) which coordinated joint engagement on matters of common interest.

The FBHSCC was provided opportunity to address the Development Partners for Health in Kenya (DPHK) on the role of the FBOs in health service delivery. CHAK General Secretary delivered the presentation on behalf of the joint team. The engagement was highly appreciated and helped to improve understanding of the Faith Based Health Sector.

Inter-Agency Coordinating Committees (ICCs)

The FBOs were engaged in the consultations on the review of the Health Sector Partnership and Coordination Framework. FBOs are represented in the various Inter-Agency Coordinating Committees (ICCs) of the Health Sector and CHAK maintained active engagement in the meetings of the various ICCs and Technical Working Groups (TWGs).

Ministerial Stakeholders Forum

The Ministerial Stakeholders Forum (MSF) which had previously been limited to private for profit, was expanded to include FBOs and NGOs. The MSF is chaired by the Cabinet Secretary for Health and is convened by MOH and Kenya Health Care Federation (KHF) twice annually.

CHAK was represented in all meetings of MSF by the General Secretary.

Global Funds Kenya Coordinating Mechanism

The General Secretary of CHAK, Dr Samuel Mwenda was appointed and served the first year as vice-chair of KCM deputizing the Principal Secretary (PS-MOH).

He chaired meetings of the KCM Management Committee and led KCM engagement meetings with the Council of Governors (CoG). The GS delivered presentations and engaged in discussion in two meetings of the Council of Governors and all CECs for Health from the various counties that discussed the Global Fund support for Kenya and ways of enhancing counties' participation in the Global Fund processes and programmes.

County engagement

CHAK engagement with County Health Departments made major progress through CHAK facilitated county engagement meetings for MHUs and also direct engagement with counties in the course of projects implementation.

The County Engagement Strategy implementation made significant progress that will be consolidated in the new strategic plan period.

Partnership engagement with NHIF and Global Fund

The Global Fund to Fight TB, HIV and Malaria has a stakeholder engagement requirement that key stakeholders be regularly engaged for information sharing and feedback gathering.

The Global Fund Country Coordinating Mechanism (CCM) for Kenya which is known as Kenya Coordinating Mechanism has provided for constituency stakeholder engagement meetings.

CHAK General Secretary who is a member of KCM from the FBO constituency and the current vice-chair of KCM coordinates the FBO constituency meeting.

Two meetings were held in March 2016 and

February 2017. Delegates included representatives from CHAK MHUs, KCCB, SUPKEM, NCCK and Evangelical Alliance of Kenya (EAK).

CHAK had 16 representatives from various member churches and MHUs. Experiences were shared on Global Fund grants implementation. From the CHAK network, experiences were shared by ELCK West Pokot on Global Fund TB implementation and AIC Health Ministries in Turkana for Global Fund HIV project implementation.

All the three Global Fund Principal Recipients (PRs), National Treasury, Kenya Red Cross and AMREF made presentations on the grants implementation progress and selection of sub-recipients.

This facilitated discussion on the best strategy for effective FBO engagement in the Global Fund processes and grants implementation opportunities.

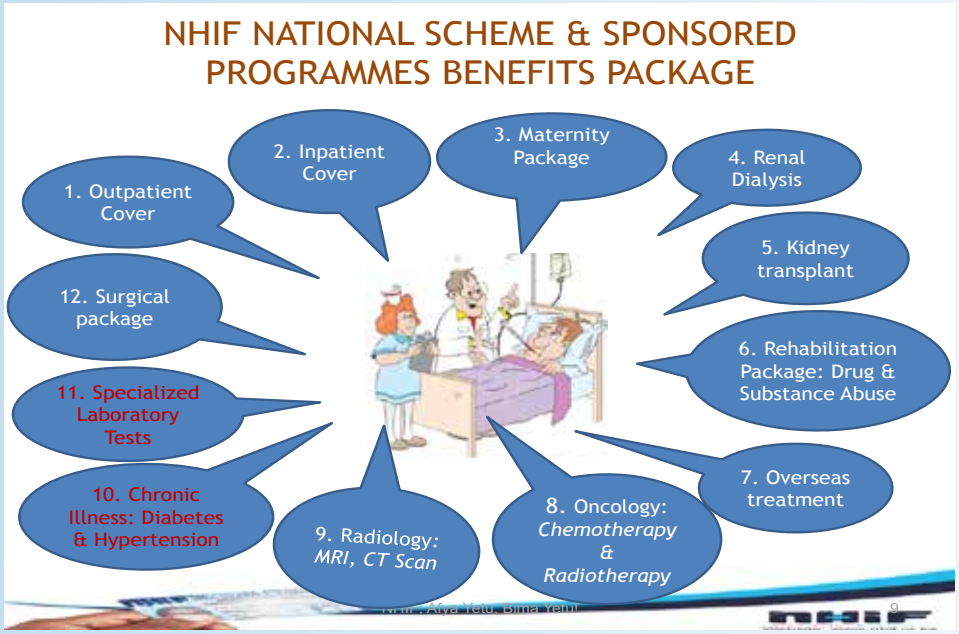
The KCM Secretariat provided information on the New Funding Application window for Kenya which was May 2017 and the application development process. The FBOs discussed and came up with a joint strategy for effective FBOs representation in the New Funding Application processes and appointed representatives to the Application Writing Secretariat and the ICCs for HIV, TB and Malaria.

The Faith Based meeting also discussed the issue of strategic engagement with National and County Governments towards enhancing recognition for FBOs and providing support to mitigate the impact created by the health workers' strikes.

Health systems strengthening, particularly health financing, is a critical subject for each joint FBOs meeting. An informative session was held on NHIF which was facilitated by Mr Geoffrey Mwangi, CEO of NHIF and Mr Ambrose Lugho, NHIF Director of Operations and Quality Standards.

NHIF announced the roll out of a new benefits package that includes surgery, dialysis, cancer treatment, rehabilitation services and Linda Mama free maternity programme that will pay for deliveries by all women.

Noting that these were good benefits to the communities, FBOs shared their proposal to partner with NHIF to engage their Faith based network in mobilization for informal sector NHIF recruitment. This proposal was well received. It was recommended that a joint NHIF-FBO technical team be established to steer the partnership forward and discuss potential for rolling out a benefits package for NCDs.



Regional and international fora

CCIH Partnership and Annual Conference 2016

CHAK values its membership to the Christian Connections for International Health (CCIH) of USA which has 168 Christian organizations globally from various denominations involved in public health. The CCIH creates a rich platform for networking, partnership and joint advocacy.

CHAK attended the CCIH Annual Conference which was held on June 17 – 19, 2016, at the Johns Hopkins University in Baltimore USA with the theme "Sustainable Development from a Christian Perspective".

There were pre-conference workshops on family planning and fundraising through proposal development to US Government and private foundations.

On June 21, CHAK attended the partners' meeting for the Gates Foundation Family Planning Advocacy Project which CHAK is implementing in Kenya. CHAK had opportunity to share on the FBO partnerships for NCDs in Kenya with specific reference to CHAK diabetes and hypertension projects.

The conference was well attended with 208 delegates from 19 countries worldwide and 26 states of USA. At the conclusion of the conference delegates participated in advocacy day events with the US Congress held on June 20, 2016.

CHAK General Secretary Dr Samuel Mwenda was presented with the third Christian International Health Champion Award which was announced by the CCIH Board at the CCIH Conference on Sunday, June 19, 2016, through Prof Henry Mosley. This was the third award since it was launched in 2014 and the first to be given outside the USA.

Dr Mwenda with the Christian International Health Champion Award with Prof Henry Mosley Professor Emeritus of Johns Hopkins University who presented the Award, Jane Kishoyian (CHAK) and Wanjiru a conference participant from Kenya living in USA.

Africa Christian Health Associations Platform

ACHAP is a networking and joint advocacy platform of Christian Health Associations and other Church Health Networks from Sub-Saharan Africa. ACHAP was established in 2007 through the leadership of CHAK following the mandate that was provided by the CHAs Bagamoyo Conference of 2007.

The Secretariat is hosted by CHAK and ACHAP was registered in Kenya in 2012. ACHAP is therefore celebrating 10 years since its inception.

The ACHAP Secretariat continued to coordinate shared learning, joint advocacy and networking among

CHAs and with partners. Following the departure of Doris Mwarey, Nkatha Njeru was appointed and seconded by IMA WorldHealth as the ACHAP Coordinator.

The World Council of Churches has remained a key partner of ACHAP. The WCC sponsored and hosted a team of 11 CHAs from Africa and India as well as the ACHAP Board to attend the World Health Assembly in Geneva in May 2016.

This provided an opportunity for ACHAP Board and Advisory Team of Development Partners to meet and discuss strategic opportunities in the new Development Agenda, SDGs.

A forum for FBOs was hosted by WCC General Secretary to discuss the contribution of faith based organizations to global public health and their strategic positioning for the SDGs. The forum was attended by WHO, Global Fund and WCC.

Discussion was held with Christian Medical Association of India (CMAI) on opportunities for south-to-south collaboration with ACHAP and CHAs for training of health workers from Africa in India.

ACHAP was also represented at the Africa Region Ministers of Health Meeting on immunizations hosted by the Africa Union and WHO at the AU Headquarters in Addis Ababa and CHAK General Secretary participated. The meeting released a commitment on working towards ending vaccine preventable diseases in Africa.

ACHAP 8th Biennial CHAs Conference was successfully held at the Thaba Bosiu Cultural Village in Maseru, Lesotho from February 27 to March 3, 2017. The Conference which had over 120 participants from diverse countries in Africa, Europe, USA and India, had the theme: "Building Partnership for FBO Health Systems Strengthening Towards achieving the SDGs".

Three parallel pre-conference workshops were held on February 27 covering ecumenical health strategy by WCC, health systems strengthening by Emory University and University of Cape Town, sexual and gender based violence by IMA WorldHealth and surgery and anaesthesia by Gradian Health and G4 Alliance.

The conference emphasized on the need to build evidence for CHAs contribution to health through research and M&E data as a strategy to support advocacy for successful partnerships.

ACHAP held a dinner to celebrate its 10th Anniversary (2007–2017) during which the journey of its organizational development was appreciated.

The General Assembly elected a new Board to steer the governance of ACHAP for the next two years. The members are Peter Yaboah CHAG-Ghana (Chair), Ms Lebo Mothae – CHAL Lesotho – Vice chair, Mathew Azonji – CHAN-Nigeria, Pierre – ECC Cameroun, Dr Ndilta – CHAD, Dr Tony Tumwisigye – UPMB Uganda, Dr Samuel Mwenda – CHAK Kenya, Dr Mwai Makoka – WCC and Mirfin Mpundu – EPN.

The new Board held it's first meeting immediately after the Conference and charted an action plan for the transition and the first year in office.

The Minister for Health for Lesotho Hon Dr. Molotsi Monyamane with Karen Sichinga (outgoing chair), Dr Samuel Mwenda, Lebo Mothae Executive Director of CHAL and Nkatha Njeru – ACHAP Coordinator following the official opening of the 8th ACHAP Biennial CHAs Conference and 10th anniversary celebration in Maseru, Lesotho.

Health service delivery

CHAK HIV&AIDS Programme

CHAK HIV&AIDS Project (CHAP)

Introduction

The CHAK/CDC HIV/AIDS Project (CHAP) is a PEPFAR-funded Kenyan HIV Care and Treatment project.

The goal of the project is reducing HIV- related morbidity and mortality in Faith Based affiliated hospitals in Nairobi, Central, Eastern and Coast Regions of Kenya through provision of comprehensive high quality health services.

In 2016, the project supported 54 facilities in 17 counties. CHAK is the prime recipient of the fund and has four sub recipients:

- HealthStrat
- Catholic Medical Missions Board (CMMB),
- Palladium Group
- Mission for Essential Drugs and Supplies (MEDS).

Implementation of the project is founded on four key strategies:
i) Mentorship and capacity strengthening of health care workers
ii) Systems Strengthening of the supported FBO health facilities
iii) Integration between faith-based and county-level health systems and
iv) Strategic Information Systems management.

Over the last five years, the project had cumulatively achieved significant milestones as tabulated below.

Overview of cumulative achievement by year ending December 2106					
Indicator	**Achievement**	**Indicator**	**Achievement**	**Indicator**	**Achievement**
No. of supported health Facilities	54	Current on ART	42,186	Viral suppression Paediatric	86%
Total clients Currently on care	42,949	Current clients on ART Adult	39,057	Cumulative client retention	78%
Adult clients Currently on care	39,714	Current clients ART Paediatric	3,129	Mother to child transmission rate	< 5%
Pediatric clients Currently on care	3,235	Viral suppression Adult (20+)	95%	HIV Testing Services	301,500

HIV prevention

HIV testing

In 2016 a total of 301,500 people accessed HIV testing and counselling services (HTS), marking a continuous growth in number of people accessing HTS from 150,000 in the send year to over 301,500 in 2016.

The proportion of paediatric patients accessing HTS increased from nine per cent in the first year to 20 per cent by the third year, especially due to the ACTS and through HTS rapid response initiatives, which also strengthened the overall scale up in the number of people accessing HIV testing services.

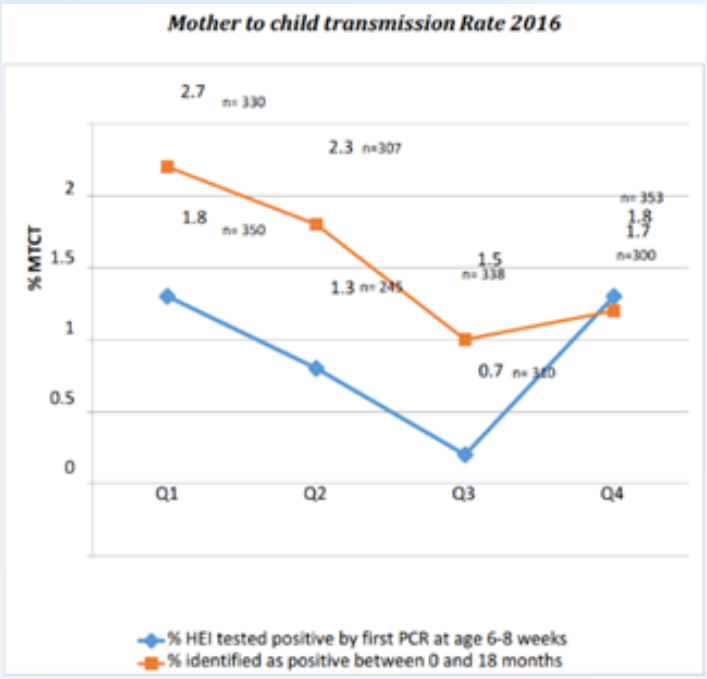
Positivity yield in the project remained below three per cent with a proportionately lower yield in the paediatric population (Attributable to successful PMTCT interventions and the relatively low prevalence in the supported regions).

The project has embarked on a data cleaning and scaling up of family testing to reach out to all HIV positive paediatric patients.

HTS at the facility out patient level has improved over the years by 50 per cent. In 2016 testing at outpatient and inpatient was 63 per cent and 93 per cent respectively. The main reason for this was improved documentation, especially the use of the linkage diaries, strategic stationing of HIV testers and eligibility for HIV testing.

The overall linkage of HIV positive to initiation of treatment in the CHAP project was 83 per cent with outpatient linkage standing at 81 per cent and inpatients at 85 per cent. Many of our large hospitals are referral centres whose patients are often on transit, making effective linkage difficult.

The mother to child transmission has remained below five per cent for the past three years. CHAP has a strong PMTCT unit which ensures early identification and intervention for HIV exposed infants, from pregnancy to cessation of breastfeeding. Onsite mentorship and supervision has further strengthened success in eMTCT.



Positive Health Dignity and Prevention (PHDP)

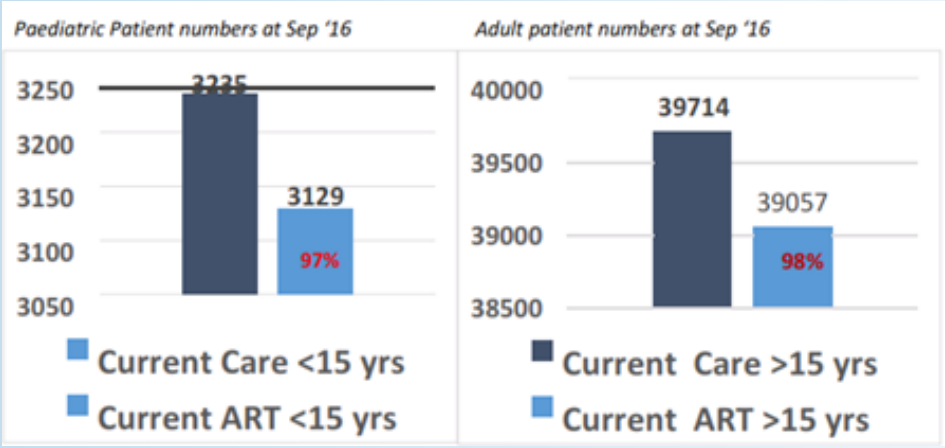
Minimum package of care received by the clients remained at 83 per cent and above. The minimum package consists of adherence plus any two other services.

Care, treatment and support

At the end of 2016, the project supported a total of 42,949 patients active on care. The breakdown in patient age-groups is shown in the chart on the following page.

The year 2016 saw the patient numbers increase as follows: New in care 5,655 and new on ART 4,749. The project achieved 61 per cent of the CDC Kenya targets, for new on ART despite meeting the testing and positivity yield targets.

The main reason for this was the low to medium prevalence of HIV in the regions that are supported.



The project had a cumulative client retention of 78.2 per cent while the 12-month retention remained above 90 per cent throughout the year.

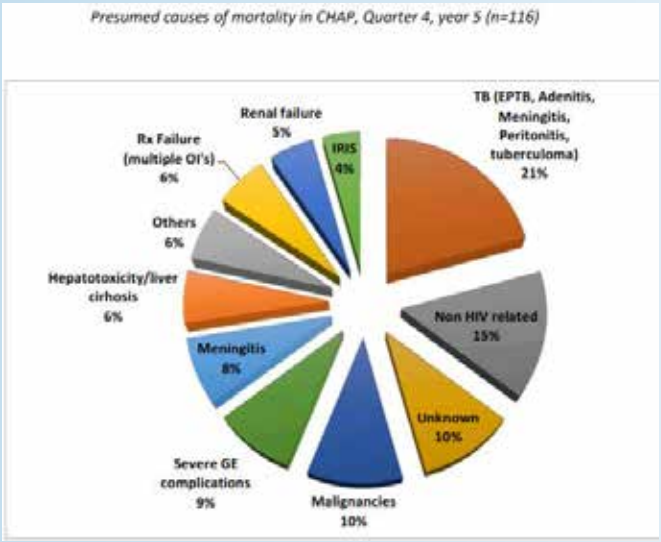
The overall viral load uptake was at 81 per cent with a viral suppression of rate of 95 per cent, 86 per cent and 78 per cent in the 20-plus, under 14 and 15-19 years age-groups, all of which were above the national average.

The viral load uptake was slightly below our desired level, mainly due to stock outs of filter papers for facilities that use dry blood spot for viral load and health care worker related factors. The project supported a patient network of over 300 support groups and over 700 peer mentors who offer comprehensive treatment adherence support which contributed to the achieved retention and viral load suppression.

The project has since supplied filter papers to the health facilities and strengthened linkages with the national laboratory for supplies and for timely results. The project continues to mentor Health care workers on quality improvement cycles that will improve viral load uptake in the facilities.

Impact of improved management of OIs (TB)

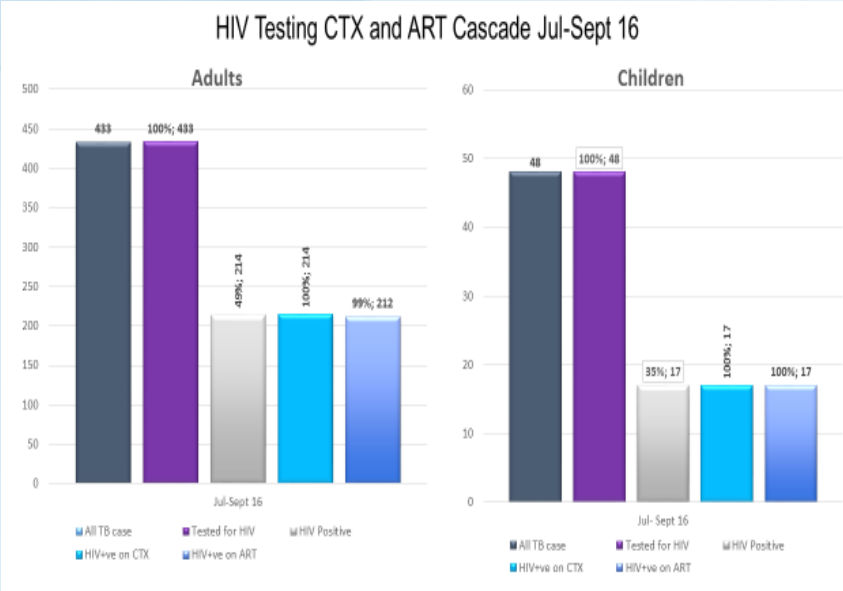
The presumed causes of mortality in the fourth quarter of 2016 are represented in the graph below:

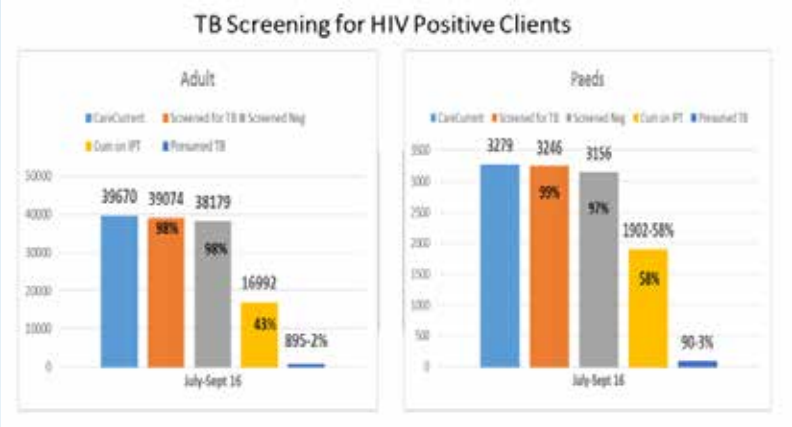


By the end of 2016 the proportion of deaths attributable to TB had fallen from about 50 per cent at the beginning of the project in 2012 to 21 per cent. The project supports dedicated TB infection prevention and control point persons and teams in all facilities. All are trained in the current infection control guidelines from the Ministry of Health.

Activities in the TB clinic for the fourth quarter have been summarized in the chart on the following page.

The overall isoniazid preventive therapy coverage was low at 44 per cent mainly due to the poor INH supply commodity stock outs.





Technical support to the health facilities

i) Supportive supervision

The project staff visited every supported facility twice every quarter to undertake mentorship, supervision and technical support. CHAK and CDC Kenya teams jointly made supervisory visits every quarter and covered a total of 18 health facilities including Voi, Kaloleni, CBHC, Mbungoni, Chaani, AIC Kijabe, St. Luke's Kaloleni, Baraka, Consolata Mathari, Tumutumu, North Kinagop, Karura, Kashiwa, Mater, Mutomo, Chogoria, Maua and Consolata Nkubu hospitals.

ii) Capacity building

The project technical team undertook facility level mentorship, trainings and updates.

County engagement

The project provided technical support on HIV strategic planning to the Embu county health team. County meetings were also held with county and sub county teams in Mombasa and Kilifi counties to discuss areas for collaboration, challenges and way forward.

Health Systems Strengthening

The project supported the roll out of paperless HMIS in Huruma, St. Joseph Kangemi and Consolata Mathari hospitals. Seven hospitals, including St. Orsola, Consolata Mathari, PCEA Tumutumu, PCEA Chogoria, North Kinagop Hospitals, Tumutumu and Chogoria were supported to develop their strategic plans in 2016.

Grant management and compliance

The project underwent expenditure analysis training and submission and Business Systems Audit by CDC Kenya in February 2016.

Title of training	Target Audience	No.
CPD (continuous professional development)	Facility component leads	200
KHQIF training	Facility CQI leads and teams	75
Biosafety	Facility laboratory in-charges	26
Pharmacovigilance	Facility clinicians and pharmacists	65
HIV testing services 2015 guidelines	Facility HIV testers	66
Youth Peer Education Updates	Facility Psychosocial Counsellors	26
2016 ART guidelines orientation	Clinical technical team	10
Satellite Management/Budgeting	CCC Coordinators	78
Governance Workshop	Hospital Administrators	25
Advanced Excel	CHAP technical team	15
Grant closeout training	Facility coordinators and accountants	42
PMD-Pro	Facility coordinators and accountants	43
Data Manager Training	Facility data managers training	23

Partnership and collaboration

The clinical technical lead became a faculty member of the HIV master TOT for dissemination of the 2016 ART guidelines at NASCOP. Five project staff were trained as master TOT for dissemination of the new M&E tools.

Project six month cost extension period

The project was granted a six-month extension period ending in March 2017 after the five year grant expiry. The project was closed by the end of March 2017. Supported activities will be passed on to the CHAP UZIMA project expected to run from 2017 to 2022.

Challenges

Human resources

The project experienced high turnover of staff as it neared closure.

Commodity stock-outs

Shortage of HIV test kits for HTS, Isoniazid for IPT and Filter papers for viral load was a major challenge at the facility level.

Human rights for PLWHIV in Kenya

Introduction

Discrimination and stigma is a common human rights violation for PLWHA. Stigmatization and discrimination hinders access to health care services by PLWHA and also affects their employment, housing and other fundaments human rights.

Consequently, this reinforces denial and silence about ones HIV status which eventually promotes further spread of the infection in communities. Stigma and discrimination discourages PLWHA from contacting health and social services and at community level when they are denied right to ownership, inheritance, education and other vital social economic rights necessary for them to improve their health and better their quality of life.

Discrimination and stigma meted toward vulnerable groups such as adolescents, injecting drug users and sex workers drives the pandemic underground.

Denial of education and information about HIV treatment, care and support services to PLWHA impacts negatively on effective responses to HIV and AIDS, slowing down efforts to stop new infections and improve the health and livelihood of those who are infected.

Enjoyment of the right to the highest attainable standards of health is vital to human dignity, life and well-being. Protection of human rights reduces vulnerabilities and therefore contributes towards reduction of new infections, promotes right to care and treatment and improves treatment outcomes.

Human rights programming is therefore essential to public health and to a successful response to HIV and AIDS.

CHAK and OSIEA took the initiative to undertake the HIV and human rights project in 2007. The

year 2016 marked the ninth year of the project's implementation.

The project works with CHAK health facilities that offer HIV/AIDS treatment and care to promote human rights for people living with HIV/AIDS.

The project aims at improving the community social support system and legal linkages to enable PLWHA to demand and defend their rights and access justice within their community and environment.

Coverage

The project covers 25 CHAK member health facilities across the country that have HIV and AIDS care and treatment programmes. The table below indicate the distribution of the participating sites per county.

County	Health facility	County	Health facility
Kiambu	PCEA Kikuyu hospital, AIC Kijabe hospital,	Kitui County	Mulango AIC heath center, AIC Zombe, Tei Wa Yesu health center
Muranga	AIC Githumu hospital,	Makueni County	AIC Kiu health center, AIC Mukaa health center
Nyeri	Tumutumu hospital		
Meru county	Maua Methodist Hospital		
Tharaka Nithi	PCEA Chogoria hospital		
Mombasa	ACK Kaloleni hospital, OASIS hospital	Homa bay	ACK Kendu bay hospital
		Kisumu	ACK Maseno hospital Ngiya health center
Bomet	Tenwek mission hospital	Elgeyo Marakwet	AIC Kapsowar mission hospital
Kericho	AIC Litein hospital	Bungoma	Lugulu Mission hospital
Kisii	Nyanchwa SDA Hospital	Kakamega	Friends Jumuia hospital
Turkana,	AIC Lokichogio, AIC Kalokol	Embu	ACF Ena hospital

Project goal and objectives

The overall project goal is to improve HIV and AIDS care and treatment outcomes and quality of life by increasing the protection and realization of human rights and access to justice for PLWHA.

Objectives

1. PLWHA empowered to demand and defend their human rights and demand better quality health care services in order to achieve better treatment and care outcomes and improved quality of life
2. Health care workers offering quality and humane health services as a result of integrating human rights into treatment and care of PLWHA.
3. The socio – economic status of PLWHIV is improved as a result of social economic and cultural emancipation and empowerment originating from the project
4. Health care workers are effectively and sustainably linked up to community mechanisms for reporting and registering client human right abuses and disputes reported to them in the course of their work while respecting the confidentiality of clients.
5. Capacity of community social structures and systems is built to ensure the community plays a pivotal role in effective response to and resolution of disputes involving PLWHIV
6. Effective, accessible, affordable and sustainable linkage mechanism between the community and collaborating legal practitioners and agencies for aiding legal and human rights disputes irresolvable at the community level are set up and are functional in all the project areas.

The current two-year project started in October 2015 and will end in September 2017.

Implementation strategies

The project is founded on a three-pillar implementation model as follows:

- The community pillar serves to build the capacity of community systems and structures to enable the community and PLWHAs to take a pivotal role in responding effectively to resolve human rights abuses and legal of disputes that face PLWHIV.

  This pillar is composed of human rights councils comprising four community opinion leaders, two peer educators and a health care worker from the health facility, who is also the overall coordinator of the Council.

- The technical assistance pillar is a panel of local legal professionals willing to work with and for PLWHAs to help them resolve both legal and human rights violations. This pillar works closely and interdependently with the health facility and community pillars as part of an empowered local community mechanism geared towards promoting sustainability of activities beyond the life of the project.

- The health facility pillar supports capacity building of health care givers to understand, identify, and integrate human rights issues into delivery of health care services in order to improve care and treatment outcomes and the overall quality of life of the client.

Project achievements

As a result of the project's implementation, PLWHA are now able to defend their rights and are aware of where to get help and avenues for seeking justice. This has increased drug adherence and health seeking behavior among PLWHA.

Awareness of HIV and human rights

Targets (Annual)	Achievements for 2015/2016
Increase awareness by 50 per cent in all 17 implementing counties	• The project developed IEC materials for use in raising community awareness on human rights for people living with HIV. The materials included posters, T-shirts, bags and training manuals specific to health care workers, peer educators and community ADR councils. • The material will be used towards supporting project activities in the remaining life of the project • PCEA Chogoria and Maua Methodist hospitals have conducted community mobilisation using the IEC materials.
Train two peer educators from HIV/AIDS psycho-social support groups in the 25 implementing MHUs	• 46 peer educators from 23 health facilities were trained on legal and human rights to build their capacity to engage their support groups on human and legal rights. • The peer educators have continued holding discussions in their support groups, ensuring that PLWHA access information on human and legal rights. • This has helped the PLWHIV to come out and share their experiences in their monthly psycho-social support group meetings and empowered them to demand and defend their rights and also come up with solutions with help from the ADR councils. • A total of 27 peer educators from 23 facilities were taken through a refresher training on HIV and human rights and are now empowering others in their support groups. • A total of 30 peer educators from different facilities were given a chance to interact and come up with strategies to enable their support group members to demand for their rights and talk out their issues. This interaction and exchange of experiences promoted learning on the magnitude and types of human rights violations common among different communities and how each group resolved them.

In 2016, 69 health care workers from CHAK member health units were trained and empowered to be TOTs in the rights-based approach to HIV/AIDS care and treatment. There are better quality health care services in the implementing facilities after integrating the rights based approach to healthcare.

The PLWHA have developed confidence in the health care workers who are now able to report different human rights violations in their facilities. The health care workers are also able to solve most of these cases reported at the community level and refer to the relevant local administration the cases that cannot be handled at that level.

Achievements in training of health care workers on HIV and human rights

Annual Targets	Achievements for 2015/2016
Train 50 per cent of health care workers in MHUs to be TOTs in human rights for PLWHA	• 69 health care workers from 23 facilities were trained on rights based approach to HIV/AIDS care and treatment and also trained as TOTs on Human rights for PLWHA in order to cascade the training to the other health care workers. This reflected 100 per cent of the set targets. • CHAK continued to offer continuous medical education (CMEs) and onsite mentorship. A total of 14 continuous medical education sessions were held and attended by 120 HIV clinic staff from seven health facilities to sensitise them on the rights based approach to management of HIV/AIDS clients. • A further 28 health care workers from 17 facilities were given refresher training on rights based approach to health care. Health care workers are the first-line recipients and managers of human rights issues affecting PLWHA and their training has resulted in greater numbers of reported cases and success in resolving them.

The community HR Councils for Alternative Dispute Resolution continued to receive and support cases from the PLWHA. During the reporting period, a total of 170 cases were reported. The health care workers and community alternative dispute resolution councils solved most of these cases at the community level. Those that could not be handled at that level were scaled up to the relevant local administration level, e.g. chiefs, assistant chiefs and police station. The reported cases are tabulated below.

Out of the total 170 cases reported, 149 were resolved through ADR councils while 21 of them are being followed up. None of the cases was referred to the technical assistance pillar, indicating that the health care workers and community ADR councils have the capacity to solve those issues.

A study to establish the impact of this increased access to human and legal rights on adherence and viral load suppression will be done between June and August 2017.

Human rights violations reported in 2016

No	Category of cases reported	Male	Female	No. of cases reported
1.	Domestic violence	7	15	22
2.	Sexual offences/assault	1	9	10
3.	Other types of assault e.g. physical violence	5	8	13
4.	Succession disputes	21	10	31
5.	Land occupancy and utilization disputes	9	20	29
6.	Stigma and discrimination	16	11	27
7.	Custody and maintenance	10	5	15
8.	Child abuse and neglect	10	13	23
	Total	**79**	**91**	**170**

Human rights councils in CHAK facilities implementing the project were activated in the course of the year. The councils whose members include the local administration and community opinion leaders offer alternative dispute resolution where the human rights of PLWHA have been violated.

The project's ADR approach through the human rights councils has made it easy for PLWHA to access justice through effective linkages between the community and collaborating legal practioners and agencies offering pro-bono services. The approach has proven to be not only effective but affordable, accessible and sustainable.

Role of human rights councils

Annual Targets	Achievements for 2015/2016
25 sites have established and are efficiently running human rights councils	• 23 out of 25 (92 per cent) sites already have an established and are efficiently running human rights councils • They have set monthly meetings to listen and settle disputes and even formulate a work plan for their activities. They have been actively involved in supporting PLWHA to resolve human rights violations. This has significantly raised the profile of their rights and has contributed to reduction in cases of stigma. CHAK will be undertaking a rapid assessment of the impact of the interventions in the coming two to three months.
All seven council members in the 25 sites are trained on Human rights for PLWHA	• A total of 161 members of the human rights council from 25 health facilities have been trained on human rights for PLWHA and how to solve disputes through ADR. Due to their composition, the human rights councils had an opportunity to get resource persons like chiefs to discuss matters such as land ownership, inheritance issues and children's rights. • 57 members of community ADR Councils in 17 facilities were given a refresher training on human rights for PLWHA. During the sessions they exchanged ideas of how best to deal with deeply rooted cultural practices that promote human rights abuse and stigmatization of PLWHA.
Support exchange learning visits in the different counties where the sites are located	• As part of their training, the community ADR councils were able to share common challenges faced by PLWHA in their localities and also proposed solutions. • Common rights violations against PLWHA within the project sites included: i. Disclosure of HIV status of PLWHA, especially by CHWs ii. Neglect of patients by families iii. High rates of dissolution of marriage only on the account of positive discordance by the negative partner iv. Neglect of children's welfare after couples' separation v. Denial of the right to inheritance, especially for women and children. • Certain human right violations are more common in some regions. Issues related to passage of rights after death such as widow cleansing and inheritance are covertly practiced in the western regions of Kenya and stigma against MSMs at the coastal region. • Greater involvement of the local administration was emphasized because of their background training and hence greater appreciation of the law, ADR and position in society.

Alternative Dispute Resolution (ADR)

Annual Targets	Achievements for 2015/2016
Legal practitioners identified to work with the 25 health facilities	During the process of identifying the regional pro-bono lawyers, it was discovered that the SDA, Methodists and the AIC churches their own internal lawyers who were ready to offer pro-bono services to the PLWHA under the care of the church health facilities. Of the 25 hospital under the project, 15 (60 per cent) have internal lawyers, a great opportunity for sustainability.
50 Legal clinics held in the 25 sites as need arises	Most cases were handled by the able local community council.
Celebrate World AIDS Day (WAD) in two counties where the project is being rolled out	• CHAK held three evening interviews at Hope FM attended by the CHAK General Secretary and Health Services Manager as panellists. One patient testimony from PCEA Kikuyu hospital was also shared. The interview created awareness on HIV/AIDS and human rights and the linkage, intervention by CHAK in partnership with OSIEA and where the PLWHA could get help in the counties where the project was being rolled out. • Six radio spot advertisements were ran throughout the month of December sensitising the community and PLWHA through audio dramatization on different issues around human rights and HIV, common human rights violations and where the people can get help. Hope FM has a wide reach in Kenya and the programme had listener and viewer responses from all over the country. • WAD celebrations were held at Oasis Medical Centre, Kilifi, and attended by more than 200 community members and PLWHA as well as county officials. The activity included: 1. Procession led by CHWs, HCWs and the local community 2. Football match with some of the Oasis CCC clients in the team which climaxed in a prize giving ceremony. The football match was meant to mobilise the community, especially men, and also sensitise the spectators on human rights through the commentator. 3. Entertainment including a poem on Human rights for PLWHA and a dramatization on the same 4. Speeches on human rights violations

Project IEC materials were developed and disseminated in all implementing health facilities to create awareness on HIV and human rights.

Monitoring and evaluation

The project manager, working with the programme officers and health facility focal point persons was able to undertake supportive supervision and support monthly supervision as detailed below.

Networking and collaboration

In 2016, the project worked closely with the following organizations to improve the impact of the project to clients:

- Local administration including assistant chiefs and chiefs, probono lawyers, churches to create awareness on human rights, government departments e.g. children's department, Land Commission and the local courts.

- The project is also working together with county health services in helping to follow up and resolve disputes that needed assistance from the county health department. Maua Methodist Hospital is working with the county health services through the sub county coordinator for HIV/AIDS in solving human rights violations against PLWHA.

Development of IEC materials

Annual Targets	Achievements for 2015/2016
Develop IEC materials with human rights messages for all MHUs	• Distributed IEC materials in 23 facilities out of 25. The materials included: 1. 3 types of manuals in line with the project implementation pillars i.e. Alternative dispute resolution a handbook for opinion leaders, Rights based approach to healthcare and Human rights for PLWHA manual 2. T-shirts 3. Posters 4. 2017 calendars 5. Bags for the peer educators • CHAK also reviewed reporting tools for each case reported and the monthly summary tools for the project to make reporting easier and more efficient. These materials were procured using the carry-over funds from the 2016 budget.

Monitoring and evaluation

Annual Targets	Achievements for 2015/2016
Visit all project sites in each quarter for mentorship and support supervision	• Site system strengthening visits were done for 23 sites. The sites were advised on better ways to roll out the programme.
Active reporting from all 25 sites	• Quarterly follow up visits and mentorship were done in the 25 facilities to evaluate the project progress, identify best practices and advise on the challenges encountered. • From the reports, stigma and discrimination which leads to violation of the other human rights is still high though the human rights councils have been actively conducting sensitisation activities.

Lessons learned

a) There are numerous cases of human rights violations against PLWHA that are not being reported or brought forward due to breach of confidence and trust. Working closely with the ADR councils and health care workers has started to bear results.

b) Community opinion leaders forming the ADR councils need to be carefully selected to keep out individuals who are driven by greed and seek to profit from the PLWHIV's problems. The project removed some ADR council members who were charging the clients they supported.

c) The presence of chiefs in the ADR councils is very valuable due to their knowledge on legal matters concerning land, succession and cultural issues among others. They were also valuable due to their capacity to enforce the decisions made by the councils.

d) The peer educators proved to be very useful in supporting services when health care workers trained in human rights left the facility and new ones came in. This bridge built by the peer educators is a strong pillow for continuity of services.

e) Facility-based or church-based legal support is useful in supporting the programme going forward.

Challenges

Frequent loss of trained health care staff is still a challenge. However, with the strengthened community ADR councils and better education and support through psycho social support groups, the clients have received good care at the sites.

Way forward

Continuous site supervision and mentorship especially for the newer facilities to ensure they fully take up the project is essential. The three pillars of the project will also be strengthened to ensure sustainability

APHIA PLUS KAMILI

Introduction

Aphia plus Kamili project is providing direct service delivery support in HIV to 73 health facilities in 11 counties in Eastern and Central Kenya.

These counties include Kiambu, Muranga, Nyeri, Nyandarua, Kirinyaga, Embu, Tharaka Nithi, Meru, Machakos, Makueni and Kitui.

The project is in its seventh year of implementation after it was extended for two years. It is supported by USAID.

Project goal

APHIA PLUS project is a consortium of four partners with JPHIEGO as the lead and CHAK as an implementer. In 2016, CHAK's mandate was mainly faith-based health facilities. The goal is to achieve the 90:90:90 strategy as per the NASCOP guidelines. The project has four focus areas:

a) HIV testing and counselling
b) Care and treatment adult and pediatric
c) Elimination of mother to child transmission
d) Maternal and neonatal child health

HIV testing services

HTC services were intensified through testing at various points in the supported FBO facilities.

The project engaged 12 sessional counselors in the high volume facilities. The counselors were given targets as per the USAID guidelines and testing intensified in the outpatient and inpatient, including pediatric wards to identify all positive clients and initiate them on treatment.

Line listing registers for identification of index clients tested were placed in the HTS areas for the counselors to work with peer educators for documentation of those tested.

Same day enrollment for the positive clients was done and the targets surpassed as shown in the table below. Pediatric testing was above 100 per cent but the number of positives identified was at 52 per cent.

Care and treatment

Supported treatment and care sites

A total of 22 care and treatment sites were supported throughout the period.

The support provided includes regular mentorship, support for CMEs and PSSG meetings, sample transportation and support for staff including clinical officers, HTC counselors, mentor mothers in selected facilities and peer educators in all established CCCs.

Mentorship

Mentorship was used to address the gaps iden-

Summary of project performance

Indicator	Achievement	APR Target	%Achievement
Adults tested	56012	36380	>100
positives	1106	630	>100
Pediatric tested	5383	4793	>100
Positives	47	91	52
Adults enrolled	706	No target	
Adults started on HAART	714	670	>100
Pediatric enrolled	42	No target	
Pediatric started on ART	45	92	49
Retention net	785	726 (12 months)	92
Women counselled and tested	9882	8736	>100
Positive women	94	166	57
Maternal ART	227	166	>100(due to KPs)
Infant prophylaxis	227	166	>100 (due to KPS)

tified through SIMS and support supervision.

Key areas of focus included early initiation of ART to eligible clients as identified during the chart reviews.

During the year, 714 adults and 45 children were newly initiated on ART. Identification of clients who were eligible and not initiated on HAART led to an increase in these numbers. Another strategy used was identification and testing of index clients, both in the CCC and PMTCT to capture family members or spouses not tested.

Appointment diaries were supplied to high volume facilities in Kiambu, Muranga, Meru, Embu and Nyeri counties for proper patient follow up. All the CCCs are now focused on 90 per cent initiation of all eligible clients and 90 per cent viral suppression.

Emphasis was placed on documentation of viral load results, identifying clients failing on treatment and management of treatment failure.

Treatment failure follow up was done and patients who failed on first line were switched to second line after discussions in the MDTs. Mentorship on IPT was also done, patients started on the same and follow up done. Screening for TB using ICF was done for over 90 per cent of clients.

Laboratory support

The project provided transport for samples from viral load, Gene Xpert, CD4 and PCR laboratory sites thereby improving accessibility to the services.

The project also supported distribution of PT panels through the sub-county Lab Management Teams to ensure quality testing across the supported counties.

Retention and VL supression strategies

Pediatric psycho-social support groups

A total of 15 facilities - Narumoru Catholic, IAP Mangu, Muthale, Mugunda, Kalimoni, St John of God, Tei Wa Yesu, and Acef Ena - were supported to hold pediatric supports groups.

A total of 290 children and their care givers attended the group meetings where health messages were passed. Parents were reminded about adherence to medication for the children. For minors above 10 years, it was advised that disclosure be done either by the care giver or clinician attending to the children.

During the holidays, most children who had missed out on support groups due to school were initiated on IPT. The pediatrics with detectable viral levels had their guardians counselled on adherence after which a repeat test was done.

Adult psychosocial support groups

A total of 460 adults from 15 facilities attended psycho-social support group meetings.

Health messages passed included the importance of family testing and effects of taking alcohol while still on medication. Treatment literacy was also discussed. The group was taken through the need for viral load testing and adherence to drugs.

Dealing with stigma and the need for dual FP methods were also discussed.

Defaulter tracing

The project supported 20 peer educators in the care and treatment sites during the period. They received airtime to enable them to reach defaulters.

Peer educators in Kiambu were supported to hold a two-day training on retention strategies for the ACT project.

Following the training, they will be required to identify defaulters from areas far from the clinics, trace them and bring them to care.

An FBO peer educators meeting was held in May and attended by 20 peer educators. They were taken through their job description and use of the defaulter tracing register.

They documented VL results in patient files upon receipt from KEMRI. The peer educators also assisted HTC counselors to invite the contacts of index clients for testing in order to identify positive clients and enroll them to care.

This improved client retention to 92 per cent in the FBO facilities.

eMTCT

In order to achieve the eMTCT goal of an infection rate below two per cent, trainings on the new ART guidelines focusing on eMTCT were conducted across the supported counties.

The staff were also trained on the new eMTCT reporting tools. The tools included HEI cards, HEI registers and the green card MOH 237 to enable them report using the new tools from January 2017.

During mentorship, the staff were sensitized on the new testing algorithm at six weeks, six months, 12 months and antibody at 18 months. Health care workers were also mentored on proper updating of the HEI register and HEI card and proper documentation of PCR results.

The HIV-positive babies were escorted to the CCC by the mentor mothers and peer educators for enrolment and initiation to HAART. The confirmatory DBS and baseline VLs were taken as per the new guidelines. The health care providers were sensitized on how to follow the PMTCT cascade from testing, enrolment, initiation, delivery and follow up for all the exposed babies

At St Mulumba, ACK Mt Kenya, Narumoru Catholic, Mugunda, Mary Immaculate and Muthale Mission Hospital, 134 PMTCT mothers had their viral load taken and most of them had undetectable viral loads.

HEI cohort analysis was done for the 2014 cohorts from January to December. The ART registers were placed in the MNCH and updated from the year 2014. Staff were also mentored on the need to fill the registers in MCH till discharge at 24 months.

Viral load monitoring was supported throughout the year. Mothers who had suspected treatment failure were followed up and given adherence counselling after which repeat VL was done after one month.

eMTCT support group meetings

Seven facilities - Mary Help of the Sick, Mulumba, Kalimoni, Muthale, St John of God, Mary Immaculate and AIC Kiu were supported to hold PMTCT support groups with a total of 1,012 clients attending. Health messages passed were mainly on hygiene, exclusive breastfeeding until six months and drug literacy.

At Narumoru Catholic Dispensary, a graduation ceremony was held for babies who had gone through the program successfully, serving as an encouragement to other mothers on follow up.

Support for health care workers

The project supported six registered clinical officers to support HIV services in Kalimoni, Kiria-ini, Mary Immaculate Mweiga, St John of God, AIC Kiu, Tei wa Yesu and Muthale Mission health facilities.

Three mentor mothers were supported in Mulumba, Kiria-ini and Mary Immaculate health facilities while 20 peer educators were supported in various project sites. A total of 12 sessional counselors were also supported.

Quality improvement

MDTs

Care and treatment sites in Lower Eastern, Muranga, Nyeri, Kirinyaga, Embu and Meru were supported to hold MDTs.

Patients with suspected treatment failure were presented to the MDTs and switched to second line. The forum was also used to address issues like nutrition and proper linkage of underweight patients. Client retention was also discussed as well as monthly reporting including the quality of data.

Discussions also centred on initiating IPT by doing intensive TB screening and stock outs. A total of 420 health care workers attended the MDTS.

SIMS

SIMS assessment was done by the USAID team at Narumoru Catholic Dispensary, Kiria-ini mission and Acef Ena. The overall score for Narumoru Catholic and Acef Ena was 78 per cent while Kiria-ini scored 84 per cent.

Gaps were identified in the care and treatment domain on partner and pediatrics testing, initiation of IPT, ART commodity management, viral load monitoring both in pediatrics and adults

and pediatric dosing charts.

These findings informed the areas of focus in subsequent facility visits across the region.

SIMS was also implemented at Mary Immaculate, St. John of God, Mulumba and IAP Mangu. An additional was identified in family testing.

Challenges

The project experienced many changes in implementation strategies due to the eminent close out expected in September 2017. APHIA PLUS Kamili had started off as a consortium of eight partners but after reorganization, only four partners remain.

APHIA Jijini

Introduction

Nairobi County has a population of 4,232,087, comprising of 2,094,247 males (49 per cent) and 2,137,840 females (51 per cent).

Children below 15 years constitute 34 per cent of the population, while youth aged 15-24 years constitute 18 per cent of the population.

The County continues to face rapid urbanization, contains the largest number of People Living with HIV (PLHIV) in the country (171,510) and has high concentration of poverty, especially in its sprawling informal settlements.

A rapid and uncontrolled population explosion, matched with an increase in internal migration as people search of better livelihood opportunities, has led to an expansion of informal settlements, where an estimated 60-70 per cent of Nairobi residents reside.

Residents in the informal settlements experience extreme poverty, overcrowding, lack of access to clean water and sanitation, a high prevalence HIV/AIDS and sexually transmitted infections (STIs).

Additionally, adolescent girls and young women living in these settlement are at a very high risk of contracting HIV/AIDS due to a myriad of factors, including a lack of education, transactional sex, and gender based violence.

Lastly, a sizeable proportion of the close to 500 annual maternal deaths in the county are likely to be found in these informal settlements.

As a result of these issues, addressing the health needs of the population in Nairobi's informal settlements is critical to reducing poverty and improving health conditions within the county.

Afya Jijini activities are a combination of prevention and curative efforts aimed at this group.

Coverage

CHAK is one of the five consortium members in Afya Jijini which is a five-year project. CHAK was initially assigned to support UHAI Team 4 consisting of Westlands and Dagoretti sub-counties.

In the fourth quarter of year one, Afya Jijini reorganized its clusters to align with the county clusters leading to CHAK transitioning to support cluster 3 consisting of Westlands, Starehe and Makadara sub counties.

This report focuses on results for the initial cluster which was supported for three out of the four quarters of 2016.

In year one, the team supported seven HIV care and treatment facilities, including four high volume sites with over 500 patients on treatment.

A total of 26 facilities were supported in MNCH/FP services, 11 of them offering maternity services.

CHAK also supports Afya Jijini HIV-TB service delivery and MNCH/RH/FP.

Project goal

Afya Jijini is a three-year contract (with two option years) designed to strengthen Nairobi City

county's institutional and management capacity to deliver quality healthcare services.

Afya Jijini's strategic goal is to "improve county-level institutional capacity and management of health service delivery."

The project's purpose is to improve and increase access and utilization of quality health services in Nairobi County through strengthened service delivery and institutional capacity of health systems.

Afya Jijini seeks specifically to achieve three main sub-purposes:

1) Increase access and use of quality HIV services (towards achieving 90-90-90 targets, and in line with the President's Emergency Plan for AIDS Relief [PEPFAR] pivot)
2) Improve access and uptake of maternal, neonatal and child health (MNCH), family planning and reproductive health, Water, Sanitation and Hygiene (WASH) and nutrition services.
3) Strengthen County and sub-county health systems.

Achievements in 2016

Access and use of quality HIV services

HIV Testing Services

- The team supported testing services for 30,856 clients with 1,138 new HIV positive clients identified
- 815 (72 per cent) of all newly diagnosed HIV positive patients were linked to care and initiated on ART in our supported facilities.
- The team supported the 'Anza Sasa' Test and Treat launched by the Ministry of Health through the National AIDS and STI Control Program (NASCOP) by holding sensitization meetings and CMEs at the sub-counties and in all supported facilities.
- The team also supported transitioning of patients in care and not on treatment to be line listed, rescheduled and initiated on ART. As a result, 96 per cent of all patients on care in the supported facilities are on ART, surpassing the second 90 target in the "90-90-90 strategy"

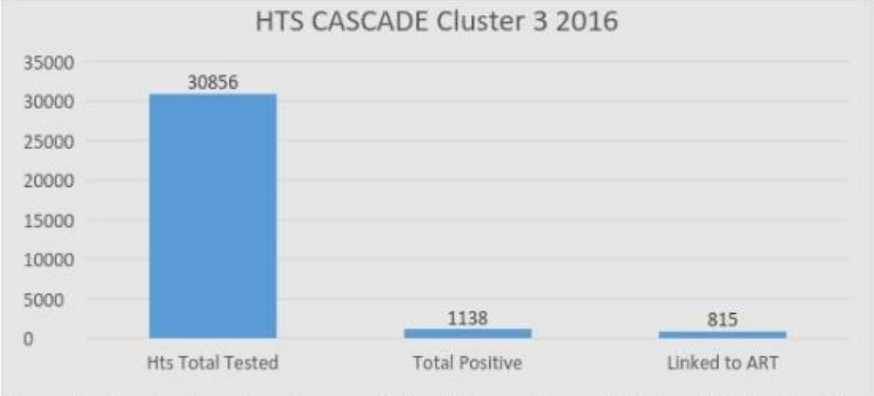


Figure 1, showing treatment access in both Dagoretti and Westlands Sub Counties.

Retention to care and treatment

AFYA Jijini UHAI 3 supported 5,388 clients in care and 4,849 clients on treatment through:

- Intensified adherence counselling by peer educators and adherence counselors in groups and one-on-one
- Daily morning support groups linked to clinical appointments in all high volume facilities
- Establishment and support of defaulter tracking mechanisms by distributing appointment diaries, linkage registers, and providing airtime and mobile phones
- Engaging clinicians and nurses in high volume facilities and mentorship on current treatment guidelines
- To foster adherence to treatment in patients new and current on treatment, the UHAI supported

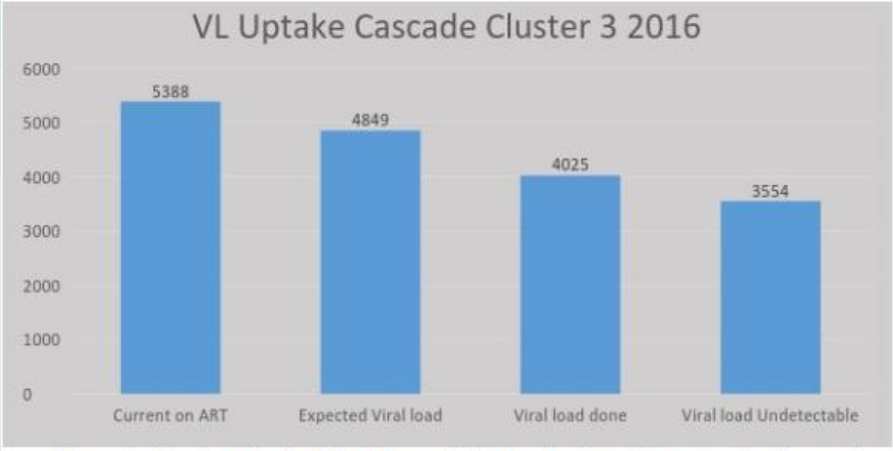


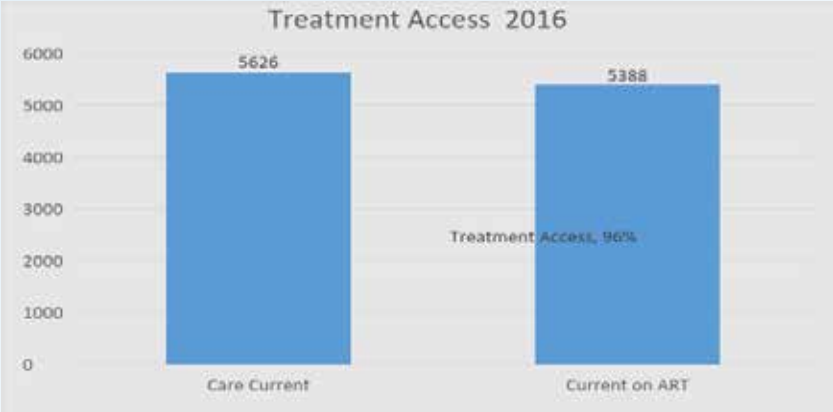
Figure 2, showing the viral load cascade in Westlands and Dagoretti sub counties

training of HTS counselors on adherence counselling using a five-day curriculum. The trained counselors offered treatment preparation classes and adherence support to the new clients prior to start of ARVs, assessed adherence and offered adherence support to unsuppressed clients during the three-month period before repeat of viral loads.

Viral load uptake and suppression

The project supported 4,025 patients to access viral load testing with a suppression rate of 88 per cent. In the second half of the year, the team supported viral load uptake RRI where facilities were enabled to bleed eligible patients for viral loads daily and through sample networking. Samples were delivered to NHRL.

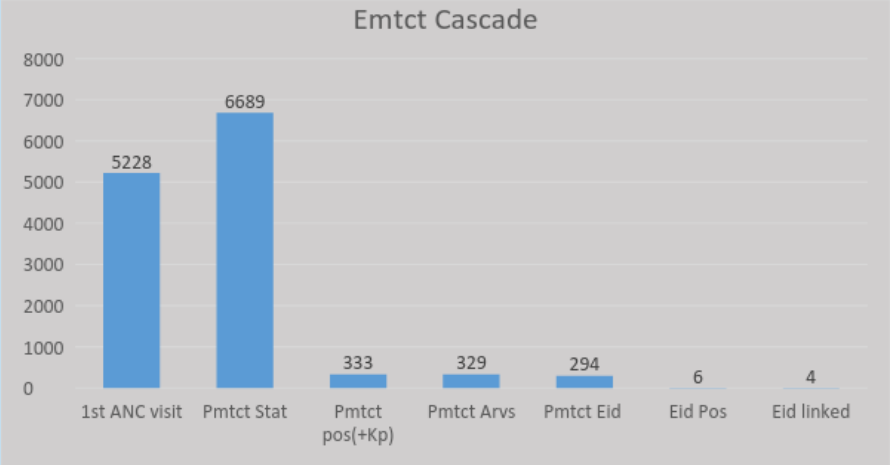
Patients with high viral loads were booked for adherence and those suspected to be failing treatment discussed in the multi-disciplinary/ WIT meetings. Actions to remedy the situations were generated from the discussions.



Elimination of Mother to Child Transmission

In 2016, the CHAK team at Jijini continued to support testing of pregnant women in all supported ANC units by enabling patient education and group pretest counselling conducted by the mentor mothers.

Through these efforts, 6,689 pregnant women were tested and 333 (5 per cent) were identified as HIV positive. A good 99 per cent of all identified HIV positive pregnant women were started on ART and linked to mentor mothers for psychosocial support.



Maternal, neonatal, and child health, family planning, reproductive health, Water, Sanitation and Hygiene (WASH) and nutrition services

Maternal and neonatal health (MNCH)

The project trained sub-county HMT and facilities on QA/QI leading to formation of work improvement teams in seven of the 11 supported maternities.

The WITs were supported to meet monthly to review different indicators and find ways of improving them. A good example is improvement of partograph use at St. Joseph Ngando where the WIT noted low completion of partograph at 49 per cent. The WIT reviewed partograph use and monitored the completeness of filling resulting in an increase to 98 per cent within two months.

The team distributed EmONC equipment to the 11 supported maternities to support skilled birth attendants. The equipment included: newborn and pediatric Ambu bags, delivery sets, room warmers, fetal scope, kiwi vacuum extractors, infant weighing scales, BP machines and stethoscopes.

This was to improve the quality and access of EmONC services In order to promote access and male involvement, the project started "We men Care" at Kangemi, Westlands, Riruta and Waithaka Health Centers. This is a strategy where detached rooms were created for men who come with their partners in MCH.

The men received HIV testing services, blood pressure checks, and screening for obesity by use of weight and height to calculate their BMI. The men also received counselling on health education. The project was able to reach more than 2000 men though "We men Care "services in the two supported sub-counties.

The sub county HMT in both counties were trained on MPDSR and supported them to meet on a monthly basis to review maternal and perinatal deaths. In the subsequent quarters, we will cascade the review to be held at the facility level and IPC color coded bins and bin lines to supported sites to improve waste management distributed

Child health

Weekend in-reaches were introduced at Kangemi, Westlands, Riruta, Waithaka Health Centers, Muteithania Nursing Clinic, Mutui-ini Hospital and Githogoro clinic.

A total of 10,094 under five children, 2341 ANC, and 782 FP clients were reached in both sub-counties. In order to increase immunization coverage, mentorship on immunization defaulter tracing mechanism was done though the actual physical and contact tracing was difficulty because no specific funds allocated to such. Both counties were supported logistically during the polio and Measles campaign and

EPI data review meetings were held in both counties to harmonize raw data documentation and reports generated at facility level and those posted/ reported on DHIS.

Mentorship of the WASH champions hired by the project in selected sites to do assessment of children with diarrhoea and rehydrate appropri-

ately was conducted .Ensured that the ORT corners were functional in all the sites that these champions were allocated.

Family planning

The CHAK team sensitized the sub counties, facility in charges and service providers on family planning compliance and also monitored compliance at facility level.

Outreach services at identified needy sites, offering integrated RH services to increase access were supported. To improve services at the facility level, the project recruited 29 RH/FP field assistants. These field assistants were to support mentorship of facility staff on FP and MNCH. The technical officer mentored the RH field assistants in different skills who eventually cascaded the acquired skills to the health care workers at facility level.

Strengthening County and sub-county health systems

Capacity building

The project set out to build the capacity of health care workers to enable then deliver quality health services by offering mentorship and OJT to improve their skills in different areas as indicated in the table below.

Table depicting the types of training done to improve the skills of HCWs

Type of Training/Cadre	Sub-County	Targets	No. Trained	Achieved %
CHV	Dagoretti	242	268	111
	Westlands	242	242	100
FP – LARC/HCW	Dagoretti	50	51	102
	Westlands	50	50	100
MIYCN/HCW	Dagoretti	63	0	0
	Westlands	63	33	52
IMAM	Dagoretti	72	40	55
	Westlands	72	40	55
FP COMMODITY MANAGEMENT / HCW	Dagoretti	30	17	57
	Westlands	30	30	100
FANC/HCW	Dagoretti	50	50	100
	Westlands	50	50	100
COMMUNITY MNCH/ CHV	Dagoretti	38	44	184
	Westlands	38	30	79
WASH/HCW	Westlands	56	56	100

Challenges

During the year, the project encountered transitional challenges after the chief of party and deputy chief of party left, slowing down activities. However, the new team leadership is now firmly in place.

Non-communicable diseases

Healthy Heart Africa hypertension project

Introduction

In Kenya, it is estimated that 16 million people (two out of every five adults) have raised blood pressure or take medication to treat raised blood pressure.

National estimates of hypertension prevalence, treatment and control are lacking. However, several recent studies have found that less than 20 per cent of urban, peri-urban and rural populations are aware of their hypertensive status, with less than half on treatment and even fewer with hypertension that is being consistently controlled.

Managing the burden of non-communicable diseases (NCDs) is a priority for the Kenya Government and NCDs have been included in the national Health Sector Strategic Plan 2013-2018. To help address these challenges, AstraZeneca entered into a partnership with CHAK in October 2014 to implement the Healthy Heart Africa programme.

HHA demonstration project was implemented for an initial period of 18 months. CHAK implemented the demonstration project between March 2015 and June 2016. The implementation was in 22 counties in Kenya through 134 health facilities (hospitals, health centers and dispensaries).

Coverage

In 2016, the project was transitioned from the pilot to the continuation phase, reducing the number of supported health facilities from 92 to 60 spread across 17 counties.

The reduction in coverage was as a result of donor driven performance based project initiatives which some MHUs were not able to achieve despite getting full support from the project management team.

Project goal

This project is part of a larger programme being implemented by a consortium of five partners with the ultimate goal of reaching out to 10 million hypertensive patients across Africa by 2024. This is in support of the World Health Organization's global hypertension target of reducing hypertension by 25 per cent by 2025. The project is founded upon four strategies:

a) Community based strategies
b) Health facility based strategies
c) System based improvements
d) Improved access to medication for hypertension.

Project objectives

1. To create awareness of and risk factors associated with hypertension in the community in order to promote prevention, early diagnosis and treatment and control of hypertension within the project period.
2. To build the capacity of the health care givers at the community and the health facility levels to enhance creation of awareness, prevention, treatment and control of hypertension.
3. To improve access to quality prevention, care and treatment for hypertension to the community by building capacity of the selected health facilities (hospitals, health centers and dispensaries) to offer hypertension prevention, screening, treatment and control services by the end of the project period.
4. To create linkages with MOH and county health services in order to improve and strengthen the prevention, treatment and control of hypertension
5. Establish an efficient and effective drugs and commodity logistic system to ensure uninterrupted and timely supply of high quality affordable antihypertensive medication to the patients.

Project achievements

Awareness creation

a) The project reached out to 618,735 persons with messages on hypertension, its risk factors and importance of screening for early diagnosis and management of complications.
b) A total of 236 community health volun-

CHAK hypertension project performance in 2016

Description of performance indicator	2016 Total
No. of patients screened	440,817
No. of patients screened with elevated blood pressure	95,916
Proportion of clients found to have elevated BP	22%
No. Patients effectively referred and Linked up for confirmation of diagnosis at a health facility	20,857
No. of new Patient diagnosed with hypertension	29,064
Proportion of patients diagnosed with hypertension	30%
No. of new patients managed on lifestyle advice	10,296
No. of new patients treated on MEDS	18,768
Proportion of patients managed on medicines	64.6%
No. of new patients treated on quality affordable access price medicines from AZ.	4,957
% Patients on AZ MEDS	26.4%

teers (CHVs) were trained on hypertension to enable them to educate the community on hypertension and its risk factors and also screen the community for elevated blood pressure.

c) The supported health facilities conducted 50 outreaches to create awareness on non-communicable diseases and screen for both hypertension and diabetes.

d) The project distributed IEC materials such as posters, t-shirts, lab coats, umbrellas, and caps with hypertension messages with the purpose of disseminating information on hypertension.

Capacity building for health care givers

a) CHAK supported on-job training and continuous medical education across all the health facilities implementing the HHA project to ensure health care providers were updated and informed of best practices for management of hypertension. The project reached over 500 health care providers in nearly 100 health facilities with OJT and on-site mentorship.

b) CHAK continues to distribute protocols with hypertension management guidelines to health care providers educating them on the current guidelines of hypertension management.

Improving access to quality prevention, care and treatment for hypertension

a) To improve the capacity of the health facilities to manage hypertension, CHAK supported allowances for 60 health facility focal point persons and 13 hypertension screening and linkage officers.

b) The project donated 20 desktop computers to health facilities with huge patient data volumes to enable easy data collection and reporting to CHAK.

c) A total of 10 screening tents were given to health facilities to enable free screening for hypertension in hospitals and during outreaches.

d) Data collection tools (education booklets, screening registers, referral vouchers and treatment registers) were distributed to support collection of screening and treatment data.

e) Health facilities were supplied with wrist digital blood pressure machines for community screening by CHVs and mercurial sphygmomanometers for blood pressure evaluation in the health facilities.

f) The project supported large health facilities with the CHAK Health Management Information System (CHMIS) to enable them collect and report data through the hypertension module developed by CHAK.

Creating linkages with MOH and county health services

CHAK has worked closely and formed a strong relationship with the Ministry of Health (Non-Communicable Diseases Department) and the various county health departments. The MoH and county heath governments undertook site supervision in some of the HHA implementation sites.

Drugs and commodity logistics system

a) CHAK has assisted many MHUs to open-

ing new or activate dormant accounts at the Mission for Essential Drugs and Supplies (MEDS) to enable them access affordable anti-hypertensive medication and assure continuous supply. In the project, MEDS is the partner responsible for ensuring efficient supply of drugs and commodities.

b) CHAK monitored the prices of project drugs to enable patients access the drugs at affordable prices.
c) The project also monitored stocks at the health facilities to ensure continuous supply of drugs and mitigate stock-outs.

Successes factors

The following lessons were learned during project implementation.

a) Engaging health facility administrators during implementation of the project is vital to creating ownership and eventual success of project operations.
b) Clearly written memorandum of understanding between the Health facility and CHAK, describing the processes, roles, responsibilities and targets of the HHA project is critical to good relations and performance.
c) Health systems strengthening at the facility is a vital ingredient for project success. As such, a well-established community health system composed of religious leaders, community health volunteers was set up to conduct education and create awareness on hypertension within the community.
d) The high turnover of staff within FBOs and the large numbers of facilities dictated that On Job Training was the best strategy for ensuring availability of skilled staff in the facilities.
e) Efficient dissemination of data tools is essential to project success as it enhances reporting.
f) Partnering with the MOH - Department of Non-Communicable Diseases has facilitated wide visibility of the project across different counties

Challenges

The huge volumes of data generated along the patient pathway, and the cost associated with data entry and supporting electronic data systems at facility level was underestimated at project planning. CHAK wishes to thank Astra Zeneca for supporting the project with such unforeseen requirement for resources.

Appreciation

a) CHAK wishes to thank Astra Zeneca for not only supporting the project financially but also for the significant involvement in its implementation.
b) We appreciate the support of the Ministry of Health and specifically the Division of Non Communicable Diseases for the support offered to us since 2014 when the project started.
c) The CHMTs and the SCHMTs in all the 17 counties that hosted the project supported the project officers in addition to supervising the CHWs during implementation.

Base of pyramid insulin access project

Introduction

This rise in diabetes is associated with demographic and social changes such as globalization, urbanization, an aging population and adoption of unhealthy lifestyles such as consumption of unhealthy diets and physical inactivity.

In Kenya, the prevalence of diabetes in adults is estimated to be 4.56 per cent according to IDF, amounting to almost 750,000 persons and 20,000 annual deaths. There is a disparity in distribution with an estimate of approximately 10.7 per cent among urban and 2.7 per cent among rural dwellers (Diabetes Atlas 2014).

This figure is based on regional projections and is likely to be an underestimation as over 60 per cent of people diagnosed to have diabetes in Kenya usually present to the health care facility with seemingly unrelated complaints. It is also estimated that about 14 per cent of the population in Kenya have impaired glucose.

As the prevalence of diabetes mellitus is escalating, patients face an even greater threat from long term complications like foot, cardiovascular, eye, nerve and renal complications that are the hall mark of diabetes and its impact.

Number of patients accessing diabetes care and insulin in faith-based facilities as per project indicators

No.	Indicator	Male	Female	Total Attended
1.	Number of Newly Diagnosed Diabetic Patients	481	676	1157
2	Number of First Visit Diabetic Patient	753	854	1607
3.	Total Number of Diabetics see in the year (Including first visit)	7084	9043	16127
4.	Number of Diabetic Patients on Insulin Only	4189	5589	9778
5.	Number of Diabetic Patients on Insulin and Oral Hypoglycaemic Drugs	1214	1603	2817
6.	Number of Diabetic Patients on Oral Hypoglycaemic Drugs Only	1408	1787	3195
7.	Number of New Diabetic Patients put on Insulin	168	1971	2139
8.	Number of diabetic patients seen who are hypertensive	3498	4918	8416
9.	Number of HbA1C test done	167	269	436

Owing to poor glycemic control, a majority of patients referred for specialized end organ damage treatment at the national referral hospitals and outside the country are diabetes patients.

Coverage

In its proposed fourth phase (January 2015 – December 2016), Base of Pyramid project was to continue with the objective of improving access to insulin as well as implementation of comprehensive diabetes care.

The focus was on the strengthening and sustaining achievements in phases 1 through 3, in the 27 counties already in scope.

The core objectives are:

- Build capacity through health care provider training and facility supervision
- Increase the number of facilities stocking insulin
- Increase awareness of diabetes and treatment options
- Increase the number of people with diabetes that access diabetes care and insulin in faith-based facilities

Project goal

The project was initiated in 2010, and its main goal was to create shared value by developing scalable, sustainable and profitable solutions that increase access to diabetes care for the working poor living in low and middle-income countries.

The BOP project works to ensure:

- Increased awareness of diabetes
- Early diagnosis of diabetes
- Access to quality care by trained health care professionals
- Stable and affordable supply of insulin
- Improved self-management through patient education

Project objectives

1. Build capacity through health care provider training and facility supervision
2. Increase the number of facilities stocking insulin
3. Increase awareness of diabetes and treatment options
4. Increase the number of people with diabetes that access diabetes care and insulin at faith-based facilities

Achievements in 2016

Building capacity of health care providers

The following trainings were done:

a) Physician mentors' forum for review of the Buddy Doctor Curriculum
b) A total of 12 CHAK project officers were trained on Comprehensive Diabetic Care by MOH, NCD department
c) A training on HbA1c for CHAK project officers was done by Meditec
d) CHAK project officers were trained on management of diabetes by Atieno Jalang'o
e) 205 health care workers were reached with the Buddy Doctor Initiative Module I and II,

while 106 were reached for all the modules (I-IV).

Insulin availability at facility level

In 2016, 49 CHAK Member Health Units stocked insulin. The pricing of insulin has been at the recommended price of Ksh500. A few facilities like Kimende Orthodox Mission Health Centre are dispensing insulin at Ksh400.

Within the same year, 2,139 (168 male and 1971 female) new diabetic patients were put on insulin.

Increasing awareness of diabetes

A total of 16,127 patients were reached on awareness and treatment options through hospital care. Another 4,683 people were also reached through community activities (CHAK AGM, Tharaka Nthi County Farmers show at Nkondi in Chogoria, outreaches in PCEA Tumutumu and AIC Githumu).

Challenges

1. Facilities prioritized reporting for communicable diseases at the expense of non communicable diseases.
2. Some sites did not stock insulin for various reasons including:
   - Few diabetic patients, especially in some level 2 facilities
   - Lack of fridges (Insulin is not allowed in KEPI fridges
3. Some facilities were buying Insulin from other sources other than MEDS, hence not giving the benefit of affordable pricing to patients.
4. There was high turnover of health care workers. Many of those previously trained on diabetes comprehensive care left the facilities, leading to inconsistency in reporting.

Way forward

- Capacity building for project staff and focal point persons through OJTs and CMEs
- Community awareness and education in partnership with KDDA
- Identification, training and management of peer educators for psychosocial support groups to increase retention and compliance to treatment
- Mentorship of project officers and health care workers by physicians
- Distribution of IEC materials for creating awareness and education
- Partnering with other NCD Programmes such as Healthy Heart Africa for establishment of NCD Clinics and for regular reporting

Communicable diseases

Global Fund Malaria New Funding Model

Introduction

Malaria situation in Kenya

Malaria is a leading cause of morbidity and mortality in Kenya. About 25 million people out of a population of 44 million are at risk of malaria.

Malaria accounts for 30-50 per cent of all outpatient attendance and 20 per cent of all admissions to health facilities. About 170 million estimated working days are lost to malaria each year (MoH 2010).

The most vulnerable group to malaria infections are pregnant women and children under the age of 5 years. Malaria is also estimated to cause 20 per cent of all deaths in children under the age of five years.

According to the Kenya Malaria Indicator Survey (KMIS) 2010, malaria transmission and infection risk is determined largely by altitude, rainfall patterns and temperature. Therefore, malaria prevalence varies considerably by season and across geographic regions.

Background of CHAK in implementation of Global Fund Malaria project

Previous CHAK experience in Global Fund – Malaria dates from the Global Fund Round 4 Malaria Project in 2006. A total of 32,000 LLINs were distributed, 631 health workers trained in case management, 466 laboratory diagnostic kits and supplies distributed through MEDS and ACSM conducted reaching approximately 92,778 people.

All active CHAK Member Health Units totaling over 500 were malaria treatment sites while some were sentinel surveillance sites.

Global Fund Malaria New Funding Model

CHAK received the Global Fund Malaria New Funding Model grant whose aim was contribute to the 2017 national goal of reducing the morbidity and mortality attributable to malaria in the various epidemiology zones by two thirds of the 2007-2008 levels.

The national objective of the grant is "Scaling Up malaria Intervention for impact".

The model aims to strengthen community systems by the increasing the number of established Community Units (CUs) from 37 per cent to 80 per cent of the required 711 CUs in Western and Nyanza Provinces by 2016.

The aim is to effectively reach children aged 5-15 years and pregnant women who are at the greatest risk of complications of malaria infection.

CHAK started implementing the New Funding Model in collaboration with AMREF (PR2) and MOH in October 2015, after a successful end of Phase II in September 2015.

CHAK was allocated the entire Vihiga County. One technical staff was deployed to the CHAK Vihiga County Office to support field activities in the spirit of decentralization.

CHAK was also allocated additional targets on health facility support supervision and malaria data quality audits in 12 counties (Vihiga, Bomet, Narok, Embu, Meru, Tharaka Nithi, Machakos, Makueni, Kitui, Marsabit, Isiolo and Mombasa).

Objectives and implementation strategies

1. Community social mobilization to create demand for increased uptake of key malaria control interventions
2. Strengthen community case management of malaria in Vihiga County
3. Support the establishment of functional community health units in Vihiga County.
4. Training of Community Health Workers on malaria case management
5. Collaborate with the SCHMTs and other

Summary of CHAK Global Fund Malaria project achievements in 2016

Outcome	Planned Year 2016	Achieved 2016	Remarks
Training of CHVs on CCMM	40	40	CHAK has successfully built the capacity of the community health systems by training community resource persons over the last four years.
Supporting CHVs with monthly stipend	410 CHVs for 12 months	410 CHVs for 9 months	The CHVs are key players in the community case management of Malaria and CHAK supported them effectively throughout the year.
Supporting CHEWs with monthly airtime for communication	82 CHEWs for 12 months	82 CHEWs for 9 months	CHEWs were also supported to motivate then to supervise the CHVs and to coordinate the case management activities effectively.
Quarterly link facility supervision	81	61	20 facilities were not supervised in the quarter between October and December 2016 but the challenge was solved and support is now fully restored.
Quarterly sub county supervision	12	12	All the activities were carried out successfully.
Quarterly M&E field visits	4	3	1 Quarterly M&E visit was not done in the quarter between October to December 2016, resulting in a 75 per cent success in operations.
Uncomplicated cases of malaria managed at the community level	4740	15,876	The targets for the activity were well achieved.
SCHMTs training on net use promotion through school pupils	1	1	Activity completed
Training of Teachers on net use promotion through school pupils	320	320	Activity completed
School health: Quarterly review meetings on net use promotion	8	1	One quarterly review meeting was conducted in the period under review due to inadequate funding.

stakeholders in implementation of malaria case management at the community level
6. Support health management teams in the sub counties and facilities to effectively carry out the core interventions that address the programme indicators in malaria control, prevention and treatment
7. To verify the quality of case management malaria indicators at the selected sites/levels and the ability of data management systems to collect, manage and report quality laboratory data.
8. To identify corrective measures and develop action plans for strengthening the data management and reporting system and improving data quality
9. To monitor capacity improvements and performance of the data management and reporting system to produce quality data

Achievements in 2016

Status of health facility support supervision and malaria data quality audit

During the year, CHAK was requested by AMREF to support 12 counties with supportive supervision and data quality assessment in order to improve service delivery at the facility level.

CHAK convened and supported a meeting of the county health CECs and directors from the 12 counties before the start of supportive supervision and data quality assessment. Following the meeting, it became clear that systems at the CHMT and county health facilities needed to improved significantly for better service delivery.

Challenges and enabling factors

- The health facility support supervision and malaria data quality audit activities, though successfully done, will need better and clearer implementation strategies in the future. The exercise was labor intensive and involved extensive travelling in the sub counties.
- A number of new health workers including the CHEWs employed by the county government recently have not been orientated in the community strategy, Community Case Management of Malaria (CMM) and use of RDTs. This makes it difficult for them to support the CHWs trained.
- Malaria commodities supply is still a major challenge with most of the link facilities still facing stock outs.

The community strategy as the delivery of basic health services is possible with involvement and collaboration of all stakeholders. The MOH and county administration are supportive and key in the roll out of the community health strategy.

Global Fund TB New Funding Model

Introduction

TB is a major cause of death worldwide. It competes with HIV/AIDS as the greatest killer globally due to a single infectious agent.

Kenya is one of the 22 high burden TB countries that together account for more than 80 per cent of the world's TB cases. The WHO estimated that there were 120,000 new cases of TB in Kenya in 2012. The estimated 9,500 (5,400-15,000) deaths due to TB make it the fourth leading cause of mortality in the country.

The major factor responsible for the large TB disease burden in Kenya is the concurrent HIV epidemic. Other factors that have contributed to this large TB disease burden include poverty and social deprivation that has led to a mushrooming of peri-urban slums, congestion in prisons and limited access to general health care services.

In order to address the challenges posed by the tuberculosis epidemic in the face of the HIV epidemic and the socio-economic environment, the Ministry of Health through NLTD-P has identified the following areas for increased support:

- Strengthening of the human resource capacity at all levels for effective coordination of TB control activities
- Decentralization of TB control services down to the community level to increase access to these services
- A stronger collaboration between TB and HIV control programs in order to promote delivery of integrated TB/HIV services
- Private public partnerships to increase the

number of private providers integrated into the TB service provider network
- Public education campaign to promote early health care seeking and adherence to treatment at community level and better TB case management by health care providers.

Case detection has been enhanced through:
- Community engagement
- Inclusion of the private sector
- Intensified case finding
- TB/HIV collaborative activities
- Increased focus on identifying TB in children

CHAK is a sub-recipient of Global Fund TB NEW Funding Model grant from AMREF.

Coverage
The project covers Machakos and Nyamira counties.

Goal
CHAK supports and shares the Ministry of Health goal that seeks to improve and sustain TB control gains in order to accelerate reduction of TB disease burden through provision of people-centred universally accessible, acceptable and affordable quality services in Kenya.

The Project implementation period is from October 1, 2015 to December 31, 2017.

Specific objectives
1. Intensify efforts to find TB 'missing" cases
2. Reduce TB transmission
3. Prevent TB active disease, morbidity and mortality

To achieve the above objectives the project adapted the following activities.

1. Community activities
(a) Contact tracing
This entails identification of the TB index case at the health facility. This case is registered by the CHEW. The CHV then goes to the household level to screen household members.

This is an intensified case finding strategy that aims to enhance early TB detection among undiagnosed TB patients. This helps in reducing morbidity and fatality due to tuberculosis by early identification and adequate treatment of TB cases, arrest further transmission by early detection of possible (secondary) cases and prevent future cases of tuberculosis in the population by detection and preventive therapy of infected high risk contacts.

(b) TB treatment interrupters tracing
The aim of this activity is to stop these patients from reaching the status of lost to follow up. It improves adherence and treatment outcomes.

(c) Health education
This is done at the household level to provide individual/ family education on infection control and counselling.

2. Stake holder meetings
The meetings target TB stakeholders in the county and sub-counties to discuss the disease burden in the regions, facility data reports, CHV activities and challenges encountered.

3. Training of health care workers
These include:
- Training of CHEWs on community based TB care is aimed at building skills, knowledge and understanding of CHEWS to be better able to supervise CHVs as they implement community TB activities.
- Training of the CHVs on community-based TB care is aimed at equipping CHVs with the skills and knowledge necessary to carry out community TB activities i.e. defaulter tracing, contact investigation, household health education among others.
- Training of prison wardens and health care workers on comprehensive service package (TB screening upon entry to prisons) improves health education and management of TB patients. This is to reach marginalized, high-risk and under-served populations, closing the case detection gap through special initiatives with adapted diagnosis and treatment models.

Project achievements
The project's achievements in 2016 are tabulated on the following page.

Challenges
- Project implementation started late due to delayed contractual process. Some of the

CHAK Global Fund TB project achievements in 2016

	Activities	Targets	Achievement Actual	Achievement %
1	Meeting for sensitization of sub county stakeholders on TB data	12	12	100%
2	Tracing contacts of smear positive TB patients	3045	655	22%
3	Tracing contacts of children under 5 years	289	3	1%
4	Tracing of TB treatment interrupters	678	364	53.6%
5	Carry out feedback meetings for providers and sub-county stakeholders to communicate results of the interventions	5	2	40%
6	Support for facility CHVs (allowances for CHVs)	30	5	16.6%
7	Integrate TB IP and strengthen IP committees	1	0	0%
8	Conduct integrated outreach services	6	1	16.6%
9	CHEWs airtime (Support day-to-day operations of Community Units -supervision)	191	125	65%
10	Meeting for sensitization of community focal persons on community based TB care	2	2	100%
11	Training of CHEWs on community based TB care	191	191	100%
12	Training of the CHVs on community based TB care	191	191	100%
13	Training prison wardens and HCWs on TB screening	30	30	100%
14	Sub county data review meeting	12	5	41.6%

planned activities were not done as scheduled.

- Few people were trained in community TB.
- Delay of disbursement of funds affected most of the community activities.

Reproductive health and family planning

Africa Christian Health Associations family planning project

Introduction

The Africa Christian Health Association's (ACHA) family planning project is a three year engagement that is being implemented by two members of the Africa Christian Health Association's Platform - CHAK and UPMB.

It is funded by the Packard Foundation with CHAK as the principal recipient and UPMB as the sub recipient.

It is estimated that the faith based communities in Africa contribute between 30–60 per cent of healthcare services particularly in rural and hard to reach areas.

Through the ACHA Platform and partners, ongoing exchange and learning has been provided to members over the years in the area of family planning including a regional conference in 2011 that focused on maternal and child health, family planning and reproductive health. Through such exchange and learning, the members of the Platform have continued to identify opportunities for integration of family planning with other health services and to learn from existing models for improved family planning service in their constituent member health facilities.

The project was implemented in 10 health facilities in Kenya and Uganda that are members of the Christian Health Association of Kenya (CHAK) and the Uganda Protestant Medical Bureau (UPMB).

Project achievements

Outcome 1: The capacity of community faith-based health networks and systems is strengthened to provide high quality, sustainable family planning information, education, counseling and service delivery

Year 1 work plan was developed by CHAK and UPMB. The organizations later held consultative

meetings with their implementing health facilities and developed individualized work plans for each facility in order to meet the project objectives.

CHAK and UPMB conducted a capacity assessment in Nyanza and Busoga region in Kenya and Uganda respectively to select four new facilities in Uganda and two new facilities in Kenya to add to the four facilities already implementing the project.

Selection of the six new implementing sites was done based on assessment findings. The UPMB selected Nabitende HC II and Kakombo HCII while CHAK selected Kendu Mission Hospital, Sagam Community hospital, Ngi'ya Health Center all from Siaya County and Kima Church of God Health Center in Butere County.

Following the selection, one project inception meeting was held with all the facility incharges from the 10 implementing sites in Kenya and Uganda during which CHAK and UPMB shared the project briefs, work plan as well as the roles and responsibilities of health workers and CHWs.

The project team also conducted one inception meeting with religious leaders to introduce the project. The meeting was to encourage ownership of project results and identify new religious leaders to join in the project implementation.

During the year, each of the 10 health facilities in Kenya and Uganda conducted outreach in their catchment areas to extend integrated family planning services to the communities. Mobilization for the outreaches was done by the CHWs and religious leaders.

CHAK expected to do 24 outreaches and achieved 32. The UPMB did all the expected 16 outreaches.
The UPMB and CHAK offered FP methods to 1,600 and 3,639 clients respectively. The clients were offered both short term and long term methods.

In Kenya and Uganda, there was an increase in new FP users. The religious leaders reached people with FP messages and education and referred 8,635 clients to the health facilities for FP services.

At two of the health facilities, Sagam and Kima hospitals, the project did not have any impact on the uptake of female condoms, bilateral tubal ligation, vasectomy, male condoms and use of cycle beads. The uptake remained at zero despite the intervention.

However, oral and injectable contraceptives uptake went up by an insignificant proportion at the two health facilities while uptake of IUCDs moderately increased.

Uptake of implants had the greatest increase at more than 400 per cent.

Similar findings was also registered in the UPMB project sites.

Another key finding was that revisits for all the methods other than injectables were much lower than new user visits across the board. This is expected for IUCDs and implants because these two do not need any refilling and are long term.

The high rate of revisits for injectables is a good indicator for continuity of use of the method and hence desirable.

Outcome 2: The capacity of faith-based health care facilities is built in order to provide affordable, equitable and high quality family planning services to the communities they serve.

The UPMB and CHAK, in collaboration with the six identified health facilities, selected and trained church leaders to conduct sensitization on family planning.

Selection of the religious leaders was gender sensitive including at least one female religious leader at each of the project sites. The religious leaders were selected across several affiliations of Muslim, Anglican, Pentecostal and SDA to ensure people from various faiths and religious backgrounds were reached with FP sensitization and awareness messages.

Through the project, 40 CHWs in UPMB and 52 in CHAK were together with facility-based providers trained to offer integrated FP services in line with existing national guidelines. Site spe-

Religious leaders and community health volunteers working in the project disaggregated by gender

Organization	Religious Leaders			CHVs		
	Male	Female	Total	Male	Female	Total
CHAK	23	19	42	12	40	52
UPMB	15	5	20	25	15	40
Total	**32**	**24**	**56**	**37**	**63**	**92**

cific capacity building plans were developed for this purpose. In each of the 10 project sites, family planning focal point persons held monthly meetings with the CHWs and religious leaders to submit monthly reports, share lessons learned, best practices, challenges faced and brainstorm on the possible solutions.

Both UPMB and CHAK offered family planning services in their facilities and distributed pills and condoms at the community level. Facilities in Uganda have been linked to Uganda Health Marketing group (UHMG) which will be responsible for delivery of family planning commodities while in Kenya the Ministry of Health supplies the commodities to faith based health facilities in Kenya.

The UPMB also procured IUCD sets, BTL and vasectomy sets to support major and minor surgical operations, ensuring reliable services.

Outcome 3: Develop a model of replication to be used in other Christian Health Associations in the sub-saharan Africa countries.

CHAK has developed a model to replicate in other CHAs. The model has been used successfully to implement new projects in CHAK such as Base of Pyramid insulin access and Healthy Heart Africa hypertension projects.

Lessons learned

- The model has worked well in the two countries to improve family planning uptake.
- Through continuous sensitizations especially by religious leaders, behavioral change aspects related to family planning such as myths and misconceptions have been be addressed.
- Religious leaders were willing to create awareness in their communities hence became family planning advocates. They also effectively referred clients to health facilities.

Community health volunteers speak

''I am now well known in my community as a trained health worker. People look forward to seeing me and hearing from me during community sensitizations.'' CHV from Uganda.

''In my community, people applauded the project. They are really appreciative for the work being done especially for having the VHTS bring services nearer to them than before.'' A CHV from Kakombo HC III.

'' One of my clients whose husband doesn't approve of her using a family planning method said that she finds it easy to come to pick pills from my home. The husband is less suspicious than if she were to pick them from the health facility.'' CHV in Kenya.

''In my community, the youth have responded well to the sensitizations. Commodities such as condoms are taken up very fast and freely. I'm always getting refills from the facility.'' CHV from Kenya

''Apart from preaching to the people in my area, I am happy that I can offer something else, information on family planning.'' Religious leader from Uganda.

"I am happy that most people from my community are coming to seek counsel on family planning from me. They have given me another name, 'Pastor of family planning'. I am happy that my community are learning this from me from a biblical perspective." Pastor from Kenya

Christian Advocacy for Family Planning in Africa project

Background information

The CAFPA project is funded by the Gates Foundation through Christian Connections for International Health (CCIH). The grant was awarded to three Christian health networks in Africa: CHAK, CHAZ and EPN in 2015 and is expected to end in 2017.

The project aims to improve the policy and funding environment for family planning through faith-based organizations in support of FP2020 strategies and goals.

Project goal

To improve the policy and funding environment for FP in Kenya by engaging and training faith-based organizations as advocates, and creating a replicable model for faith-based advocacy for family planning.

Project objectives

1. To increase the capacity of local faith-based health facilities to advocate for improved family planning policies and resources by improving MOH and other organizational commitment to working with FBOs on FP and on contraceptive commodities.
2. To establish and disseminate a faith-based advocacy model for policy change and resource mobilization to be used by other CHAs and FBOs to advance the goals of FP2020.

Project achievements

Quick wins

- Improved support for FP commodities from County Health Departments to FBOs
- Improved FP uptake and Improved method mix at health facility and community
- Demystifying myths and misconceptions driven by beliefs and culture through religious leaders advocacy at community level
- Development of the family planning advocacy guide for faith communities

CHAK and CCIH conducted an advocacy through media communication training for nine religious leaders and 3 CHAK staff.

The meeting's objectives were to review and update the religious leaders on the advocacy plan created in October 2015, to educate the religious leaders and staff on media tools and how to reach out and respond to various media. The training was also to ensure faith leaders' messages about family planning are heard through the mainstream (TV and radio) by Kenyans across the country.

Project coordinator Jane Kishoyian explains the different family planning methods available during a live television show.

Updates on family planning statistics in Muranga, Meru and Kiambu counties were given.

Two religious leaders accompanied by the CHAK Health Services Manager had a live talk show on Family Radio, one of the Christian radio stations in Kenya. Kenyan from all counties had an opportunity to engage with the religious leaders on family planning as the religious leaders supported the services and encouraged the community to go for them.

The Project Coordinator went on a live show on Inooro TV to discuss family planning methods as she advocated for budgetary allocation for family planning at the county level. The interactive show also discussed the myths and misconceptions surrounding different family planning methods.

The opportunity was also used to encourage mothers to go for skilled birth attendance to reduce maternal mortality and morbidity as well as reduce neonatal mortalities.

CHAK also organized and conducted interviews for the religious leaders and health care workers from implementing health facilities. This was

Father John Waihiga of Kimende Orthodox Church explains the importance of family planning to his congregants. Also present at the meeting were CHAK and CCIH staff.

aimed at identifying achievements against the baseline assessment.

In the three implementing counties, (Muranga, Kiambu and Meru) it was evident that the health facilities had increased stock of FP methods as well as other consumable commodities.

The health workers appreciated the involvement of religious leaders in engaging their sub County and County Ministries of Health to ensure reliable supply of family planning commodities.

Two facilities, namely PCEA Bibilioni Health Center and ACC&S Tata Hannah in Kiambu and Muranga respectively started receiving the health center kit 1 which the MoH had stopped supplying to them. The kit contains essential drugs for different ailments.

Health care workers from seven health facilities reported receiving the latest guidelines and job aids from the County. The facilities also experienced improved FP uptake. This was attributed to religious leaders and CHVs engaging in community education and support for FP. The religious leaders used plarforms such as the church, community meetings including burials, weddings and other social gatherings, women and men groups to share FP information as they dispelled myths and misconceptions about FP.

The religious leaders expressed satisfaction with the work they were doing and appreciated the Gates Foundation, CCIH and CHAK for the training they had received.

"If it were not for the training I had, I would not be able to talk on radio, give information on FP and advocate for these important services. I now know that it is my responsibility to talk about FP and support it. I know I can do much more in my community," Reverend Njunge from AIC Githumu said.

The Project Coordinator attended the ICFP conference in Indonesia and shared family planning and RMNCH best practices in two forums.

She also attended two TWG meetings on FP and one on MNCH. Meetings with partners such as DSW and World Vision were held to discuss each partner's work in FP and RMNCH. Challenges in the counties, especially in the entry point were discussed with World Vision as well as possible solutions.

CHAK shared reporting tools and training materials for religious leaders with World Vision.

The Poject Coordinator and General Secretary attended the CCIH 30th Annual Conference which was held in Baltimore USA. The project Coordinator presented on 'engaging communities and religious leaders to promote healthy behavior.

A key lesson learned was that if religious leaders were trained and given a platform to engage the community and government on family planning issues, uptake of FP methods could increase three-fold in each facility. Religious leaders, CHVs and health care workers need to work as a team to achieve this.

A partners meeting was held in Washington DC

with representatives from CHAK, CCIH, CHAZ and EPN with the objective of reviewing each partner's progress and sharing experiences. During an advocacy meeting at Capitol Hill with the Senate, the FBO partners encouraged the US Government to support family planning bills and financial aid for Africa.

CHAK was also represented in the family planning technical working group at the national level. Information on the roll out of the new NXT implanon was given.

Meetings led by the MoH discussed issues surrounding implant removals. A survey done in five counties showed that there was a problem with the removals. Through the deliberations, challenges such as skills in removal as well as deep insertions into the muscle were highlighted. The department of family health is continuing to look into the issue.

Through CHAK collaboration and religious leaders' engagement with the County Governments, some health care workers from faith based facilities have been trained on the new NXT implanon insertion and removal.

In Meru County, religious leaders, health workers and opinion leaders came together and formed a committee to engage the health ministry.

This committee and CHAK organized for a one-day meeting with the members of the County Executive Committee on Health. The religious leaders committed themselves to support family planning activities in the county and requested the County government to consider allocating a budget for FP. The CEC informed the gathering that the family planning budget for the county was included in the RMNCH package.

The CEC was pleased that the church was in support of FP and promised to continue assisting the FBO health facilities with FP commodities and training of health care workers.

An advocacy meeting with the Meru County Governor saw Kiegu Health Centre assisted with two computers to help them in data entry and analysis.

CHAK facilitated quarterly support supervision in the three counties. This was an opportunity for the religious leaders to review their workplan and share experiences.

Additionally, CCIH released a collection of resources to help faith-based organizations advocate for family planning with the engagement of religious leaders.

Christian Health Associatiion of Kenya, Churches Health Association of Zambia, the Ecumenical Pharmaceutical Network and CCIH developed a step-by-step guide to help organizations train religious leaders to advocate for family planning with their communities, governments and the media. The guide is available in English and French.

The guide was inspired by the work done with religious leaders by Christian Health Association of Kenya (CHAK), the Churches Health Association of Zambia (CHAZ) and the Ecumenical Pharmaceutical Network (EPN).

Maternal, neonatal and child health

Background information

Kenya has made notable progress in improving maternal and child health outcomes. However, despite the progress, Kenya could not achieve the Millennium Development Goals for maternal and child health.

It is clear that a lot more still needs to be done by Kenya to address the supply and demand side barriers in the delivery of essential health services in order to realize the goals of Vision 2030 and the 2010 Constitution. The Bill of Rights clearly articulates the right to health for all, including reproductive health.

There have been notable improvements in service delivery during the past three years in Kenya. The county governments have given priority attention to expanding primary health care networks and enhancing effectiveness in service delivery.

Access to emergency obstetric care has improved in counties that faced long-standing challenges in making facilities operational. However, more focused effort is required to eliminate preventable maternal and child deaths and improve health outcomes.

In 2016, CHAK health facilities responded to the complex nature of the issues surrounding the practice and delivery of ANC and prioritized person-centred health and well-being of pregnant women. The ANC performance in CHAK facilities was as follows:

CHAK MHUs ANC performance data

Indicator	CHAK MHUs performance data
ANC Breast exanimated	543,189
ANC Client Supplemented with Combined Iron and Folate	447,444
ANC Client given Iron	295,045
ANC Client given folate	206,494
ANC clients Syphilis +ve	3,500
ANC clients tested for syphilis	282,588
ANC given exercises	223,138
Adolescents (10-14 years) presenting with pregnancy	7,222
Children under 1Yrs distributed with LLITNs	65,021
Clients given IPT 1st Dose	95,845
Clients given IPT 2nd Dose	88,676
Clients with Hb <11g/dl	57,531
LLITNs distributed to ANC clients	244,646
Mother counselled on infant feeding options	232,998
New ANC clients	386,947
Pills Combined oral contraceptive	156,886
Pregnant women completing 4 ANC visits	201,610
Re-Visit ANC Clients	763,562
Adolescents (15-19 years) presenting with pregnancy	75,768

Maternity and deliveries

The period of birth is critical in the life of both the mother and the baby. Ideally, the mother needs to be assisted in a competent manner by a skilled birth attendant supported by an enabling environment.

CHAK health facilities contributed towards increasing skilled birth attendance and postnatal care as follows:

CHAK MHUs maternity and deliveries performance data

Indicator	CHAK MHUs performance
Adolescent (10-19yrs) maternal deaths	407
Assisted vaginal delivery	2241
Babies discharge alive	273455
Babies given tetracycline at birth	136281
Birth with deformities	379
Births with low APGAR score	4141
Breach delivery	2769
Caesarian sections	39175
Deliveries from HIV+ve Women	9110
Fresh still birth	3644
Infants initiated on breast feeding within 1 hour after birth	174221
Live birth	288352
Macerated still birth	2765
Maternal deaths audited	241
Maternity referrals from other health facility	9211
Neonatal deaths	3136
Normal deliveries	255825
Pre-term babies	8867
Total maternal deaths	302
Underweight babies <2500gms	14595

Immunization

The basic principle of immunization is to administer into a healthy person a vaccine that will prevent that person from getting a certain disease. The performance of CHAK MHUs in immunisation is presented in the table on the following page.

Capacity building of MHUs in MNCH

In 2016, CHAK with support from Bread for the World in collaboration with the Ministry of Health (DRH) and Micronutrient Initiative organized training for health care workers on the Essential Newborn Care and Basic Essential life-saving skills for MNH/Basic and Comprehensive emergency Obstetric care (BEmOC/CEmOC).

Broad objective of the training

The main aim of the essential newborn care (ENB) and BEmOC&CEmOC training was to equip the service providers with updated knowledge, skills and appropriate attitudinal concepts to enable them improve quality in provision of maternal and neonatal emergency care in their health facilities.

Specific objectives

1. Describe the major causes of maternal and newborn mortality in Kenya
2. Describe the different elements of Focused Antenatal Care and how to apply them in or-

CHAK MHUs performance in immunisation

Indicator	CHAK MHUs performance
Adverse Events Following Immunization(AEFI)	1475
BCG doses Administered	395558
DPT/Hep+HiB1 doses Administered	382883
DPT/Hep+HiB2 doses Administered	363978
DPT/Hep+HiB3 doses Administered	358247
Fully Immunized Child(FIC)above 2 years	2690
Fully Immunized Children(FIC) under 1 year	333686
IPV doses Administered	272354
IPV doses in stock at the beginning of the Month	605834
IPV doses received within the Month	291691
IPV doses remaining at the end Month	595460
Measles-Rubella 1 doses Administered	351007
Measles-Rubella 2 Dose Adm (at 1 1/2 - 2 years)	143893
Measles-Rubella 2 Dose Administered >2 yrs	15420
OPV Birth doses Administered	311455
OPV1 doses Administered	378087
OPV2 doses Administered	357717
OPV3 doses Administered	348745
Pneumococal 1 doses Administered	381807
Pneumococal 2 doses Administered	360783
Pneumococal 3 doses Administered	356795
Rotavirus 1 doses Administered	367816
Rotavirus 2 doses Administered	336547
Squint/White Eye reflection Under 1 year	6233
Tetanus Toxoid for Pregnant women	423398
Vitamin A 2 years to 5 years(200,000 IU)	870867
Vitamin A Supplemental Above1 Year(200,000IU)	25933
Vitamin A Supplemental Lactating Mothers (200,000IU)	252283
Vitamin A Supplemental under 1 Year(100,000IU)	12504
Vitamin A at 1 1/2 years(200,000 IU)	256319
Vitamin A at 1years (200,000IU)	287839
Vitamin A at 6 months(100,000 IU)	310679
Yellow fever doses Administered	4998

der to achieve a good outcome for the mother and baby and prevent any complications that may occur in pregnancy, labour, delivery and post-partum period
3. Explain the signal functions of Basic and Comprehensive Emergency Obstetric and Newborn Care (B/C EOC) packages of service delivery
4. Explain the pillars of maternal and newborn health as laid down by the Ministry of Health
5. Explain the different causes of obstetric emergencies
6. Demonstrate the skills needed to manage these obstetric emergencies
7. Demonstrate ability in the use of the revised WHO Partograph in recording the progress of labor and monitor the condition of the mother and the fetus.
8. To recognize slow progress in labor and manage it appropriately
9. To recognize obstetric hemorrhage and practice the skills needed to respond to a woman who is bleeding
10. Assess all newborns for general danger signs and main symptoms
11. Assess all newborns for signs of very severe disease and local bacterial infection and jaundice
12. Routinely assess all newborns for, HIV infection or exposure ,nutritional and immunization status
13. Correctly identify the newborns illness and provide appropriate treatment
14. Counsel caregivers on home care, appropriate feeding and when to return to the health facility immediately or for follow-up.

A total of 29 participants drawn from 29 MHUs were trained on BEmOC&CEmOC while 122 were trained in ENB care.

Lessons learned

1. Implementation of ENB and BEmOC/CEmOC interventions requires open dialogue between the community and health care system at all levels.
2. Addressing the three delays through community sensitization, advocacy and networking, improvement of referral systems as well as availing basic equipment and supplies to both the BEOC & CEOC facilities to effectively manage the emergencies and referrals is a pre- requisite to improvement of MNH care.
3. Effective leadership and supportive supervision is a basic requirement to elimination of the third delay at the facility level.
4. Building a critical mass of skilled service providers in management of obstetric emergencies is a basic need to improving the MNH care
5. Establishing emergency teams and protocols is a positive step towards improving MNH care.
6. A successful BEmOC and CEmOC skills training requires competent facilitators, adequate training resource materials/aids, commitment of both the facilitators and trainees and effective management support.

Suggestions for improvement of MNH care

1. It is important for all health facilities to ensure availability of drugs, supplies and equipment required for preparedness and prompt action in managing emergency cases especially KIWI and MVA kit.
2. It is important to print and avail the latest MOH Emergency Obstetrics and Newborn Care Guidelines in the service delivery areas in all health facilities.
3. CHAK staff will support the trained service providers to implement the action plans they developed at the end of the training as they do support supervision.
4. Monitoring and evaluation of the MNH service uptake and quality of care improvement is continuous.

Health Systems Strengthening

Health Systems Strengthening

Introduction

CHAK strengthens the support systems of MHUs through various initiatives. In this reporting period, support was given in the following areas:

- Human resources management and development
- Hospital management information systems and software
- Financial management
- Drugs and pharmaceutical supplies and commodities
- Monitoring and Evaluation
- Standards and quality assurance
- Medical equipment procurement, repairs and maintenance
- Development of building infrastructure

The highlights of the various support efforts to MHUs are shared in the sections that follow herebelow.

Capacity building in project formulation and proposal writing

In response to requests by MHUs through the Regional Coordinating Committees (RCCs) for capacity building in health projects formulation and proposal writing, CHAK organized and conducted a national workshop on project formulation and proposal writing. The workshop was held in June 2016 at CHAK Guest House, Nairobi.

Attendance at the workshop was 26 participants from 26 MHUs.

National workshop on project formulation and proposal writing.

Strategic planning support for member health units

In this reporting period the strategic planning process for AIC Kapsowar hospital was completed. The final draft for action by the hospital has been produced.

Capacity building in management and governance

Training workshops

In response to the needs in management and governance capacity by MHUs, support was given to MHUs through four separate regional workshops that covered a total of 122 MHUs. The workshops focused on imparting knowledge, skills and information through power point presentations, plenary discussions and experience sharing.

Management Workshop for Western and North Rift region held in Kakamega.

For MHUs in Western & North Rift region, the workshop was held in August 2016 in Kakamega while for MHUs in Nairobi, Central, South East and Coast region, the workshop was held in September 2016 at CHAK Guest House in Nairobi. For MHUs in Eastern & North Eastern region, the workshop was held in September 2016 in Embu, and for Nyanza & South Rift region the workshop was held in October 2016 in Homabay.

Management Workshop for Eastern and North Eastern region in Embu.

Management Workshop for Nyanza and South Rift held in Homa Bay.

Experience sharing exchange visits

Experience sharing learning exchange visits between facilities continues to be cherished as an effective way of transferring knowledge and best practices from one facility to another. In this period, applications for support towards exchange visits were received and approved as follows:

AGC Tenwek hospital was supported for an experience sharing visit to Mater hospital, Nairobi hospital, AIC Kijabe hospital, Gertrude Children's Hospital and Nyeri-Mathari Mission Hospital. MCK Maua hospital was supported for a benchmarking exchange visit to PCEA Chogoria Hospital and Kirwa Mission hospital. PCEA Chogoria Hospital Chaplaincy Ministry was supported for a learning exchange visit to AIC Kijabe Hospital Chaplaincy Ministry. Tumutumu hospital was supported to a benchmarking visit to Chogoria and Kijabe Schools of Nursing.

Visit by Tenwek to Gertrude's Children's Hospital.

Visit by Tenwek to AIC Kijabe Hospital.

Support to governance of MHUs

Board meetings

In this reporting period CHAK supported and participated in meetings and activities for governing boards of the following 11 MHUs: ACK Maseno hospital, ACK St. Lukes Kaloleni hospital, MCK Maua hospital, PCEA Kikuyu hospital, Friends Lugulu hospital, AIC Kijabe hospital, AIC Githumu hospital, PCEA Chogoria hospital, PCEA Tumutumu hospital, AGC Tenwek hospital and Tei Wa Yesu health Centre.

Board induction and capacity building

In response to requests by two hospitals and three health centres under the Church of God (CoG) for support in Board induction and capacity building, CHAK organized and held a joint workshop for four facilities at Kima Mission Hospital in November 2016. The four facilities were Kima hospital, Mwihila hospital, Mundoli and Bushiangala health centres.

The Board members and the hospital management team members participated. The focus of the workshop was induction on Board roles as distinguished from management roles and capacity building in relevant management and governance aspects.

Board orientation for COG health facilities in Western region.

Regional Coordinating Committee (RCC) activities

Performance Review and Planning meetings

In February/March 2016 the RCCs held meetings to review activities' implementation in 2015 and to plan for the year 2016. The RCC activities in all regions reached 122 MHUs. The planning meetings referred to above were held on dates and venues shown herebelow:

- Nyanza & South Rift – Venue: Kericho AGC Church in February 2016
- Western & North Rift – Venue: Kakamega in February 2016
- Eastern & North Eastern – Venue Embu in February and November 2016
- Nairobi/Central/Coast & South East – CHAK Offices in February 2016

RCC planning meeting for Western and North Rift region.

County engagement

CHAK sought appointments for introductory as well as follow up meetings with County Ministries of Health. In this period, county engagement covered Kitui, Muranga, Kericho, Uasin Gishu, Nakuru, Meru, and Tharaka Nithi.

The counties were generally agreeable to partnerships with CHAK to support health service delivery through sharing the limited resources available.

Left: County engagement meeting for Muranga County and (right) for Nakuru County

Architectural support

The architectural support provided covered whole or part of the scope of normal architectural services. These are client briefing and site investigations/evaluation, preliminary design, detailed designs and tender documents, pre-construction contract services, construction period services and post-construction period services.

The following MHUs were supported.

AGC Tenwek Hospital

- Prepared architectural proposal for a satellite hospital in Bomet town.
- Continued supervision of construction works for the eye and dental unit. The project is nearing completion.
- Provided supervision and administrative support to the proposed dining and multi-purpose hall for the School of Nursing

Ramp for the Tenwek Hospital Eye and Dental project.

PCEA Tumutumu Hospital

- Architectural proposals were produced for rehabilitating an existing staff house to accommodate medical doctors on internship at the hospital
- An architectural proposal for hospital entry/parking was developed.

MCK Maua hospital

- Architectural design for remodeling of OPD, casualty, eye unit and community health

- Architectural design for remodeling HIV and chest clinics

RONDA Fund proposals

CHAK assisted five hospitals to consolidate proposals and submit applications to Ronda funding towards civil works infrastructure and medical equipment. These facilities were Tenwek hospital, Kijabe hospital, Chogoria hospital, Maua hospital and Kapsowar hospital

Inspection of works for the Tenwek Hospital Eye and Dental project.

Medical equipment maintenance and repairs

Introduction

CHAK National Health Care Services (NHCTS) workshop offered a wide range of services and support to both KCCB and CHAK health facilities and others. These included the following:

- Installation, repair and maintenance of X-ray equipment and associated accessories
- General medical equipment repairs and maintenance
- Installation, repair and maintenance of anaesthesia equipment
- Technical advice to the MHUs on procurement and maintenance of medical equipment
- Hospital plant maintenance e.g. power generators, oxygen generators and cooling plants
- Trainings

NHCTS technician Julius Nkandika showing an ultra sound machine in the workshop.

Achievements

Key achievements in 2016 are summarised as follows.

Donations of equipment and user training

CHAK National HCTS Workshop continued receiving donations of new medical equipment from Rotary club of Australia World Community Service (RAWCS). Additionally, two new anaesthesia machines were donated by DAK foundation and supplied to Maua Methodist Hospital and Dophil Maternity and Nursing Home.

Estimated market value of equipment donated to various MHUs was Ksh8 million and included the following:

- 7 Ultrasound machines and user training to benefitting hospitals
- 4 Vital sign monitors
- 1 ECG
- 1 Oxygen analyser
- 1 Patient monitor
- 1 Suction machine

Beneficiaries of donated equipment

MHU	POC ULTRASOUND MACHINE	VITAL SIGN MONITOR	IM8B	PULSE OXIMETER	ECG	PEDIATRIC ACCESSORIES PARK	M_3A VITAL SIGN MONITOR	SUCTION UNIT
St. Mary's Hospital Mumias	1							
Port Victoria Sub-County Hospital	1							
Sololo Mission Hospital	1							
St. Anthony Health Centre Abossi	1							
Sagam Community Hospital	1							
St. John of God Hospital-Tigania	1							
AIC Kapsowar Mission Hospital	1							
Lwala Community Health Centre		1			1		1	
Plateau Hospital			1			1		
Sega Mission Hospital				1		1	1	1
RGC Oasis Medical Centre							2	

Supply and installation of equipment

This was done as follows:

- Baby Incubator at ACK Mt. Kenya Hospital
- Anesthesia machine in Nanyuki Cottage Hospital
- X-ray machine in Holy Family Catholic Hospital, Githunguri
- Dental chair/equipment in Oasis Medical Centre, Mombasa
- X-ray machine in Oasis Medical Centre, Mombasa
- Oxygen gas manifolds and identification of gases at Nanyuki Cottage Hospital
- Power management module for the autoclave at Nanyuki Cottage Hospital
- Portable autoclave machine at Tenwek mission Hospital
- X-ray batteries for the general x-ray machine for AIC Cure international Hospital, Kijabe

Medical equipment maintenance and repairs

i) Radiation safety services

The NHCTS workshop license for radiation safety assessment and quality assurance was renewed by Radiation Protection Board.

Radiation safety assessment, installation of lead sheet and approval of new x-ray room, was done for the following facilities:

1. Oasis Medical Centre
2. Navakholo Sub-county Hospital
3. Matungu Sub-county Hospital
4. Lumakanda County Hospital

ii) Equipment maintenance and repairs

CHAK member health units were supported as follows:

- 15 MHUs in basic equipment repairs and maintenance
- 27 MHUs in x-ray machines maintenance services
- 12 MHUs in anaesthesia machines maintenance services
- 37 MHUs with technical advice on medical equipment procurement and maintenance.

Standards for medical equipment and devices

The NHCTS technicians represented CHAK at Kenya Bureau of Standards (KEBS) in the technical committee on hospital equipment and devices standards.

The following were achieved in the committee:

- The standards for obstetric bed, paediatric bed and baby cots were released for implementation.
- Evaluated and adopted improved standards by ISO on various medical equipment and devices

Technical working groups presented standards for the following:

1. Obstetric beds

2. Reviewed and adopted standards for six surgical implants.
3. Reviewed and adopted standard for anaesthetic reservoir bag
4. Reviewed and adopted standard for medical masks and protective clothing
5. Reviewed and adopted standard for lung ventilator for medical use

Challenges and constraints

In the systems strengthening efforts at CHAK, the following challenges were noted:

- The demands of MHUs for support continue to exceed the available technical capacity and resources
- Stiff competition from other market players
- Debtors
- Fast technological changes requiring faster compliance
- Keeping up with the latest calibration and servicing equipment and tools

Summary of NHCTS income and expenditure for 2016

Income (Ksh)	Expenditure (Ksh)	Surplus (Ksh)
11,861,963.00	13,071,363.00	(1,290,401.00)

Summary of work done, paid work and debtors for 2016

Work done	Paid work	Debtors
11,861,963	7,828,683	4,033,280

Summary of services offered by National HCTS workshop in 2016

Category of Service	No. of facilities served	No. of jobs done
X - Ray	27	27
Anesthesia	12	31
General	15	34
Technical advice	37	6

Quality management

Introduction

Kenya's devolution process has increased competition in the health sector tremendously. In addition health facilities are being audited by NHIF regarding quality to support their rebates system. Therefore, it is incredibly beneficial for CHAK members to improve the quality of health care and health services.

Quality of health care is currently a priority objective in Kenya. In 2011 the Department of Standards and Regulations in the Ministry of Health (MoH) launched the Kenyan Quality Model for Health (KQMH).

At the end 2016 the KQMH was under review with CHAK as a key participant in the process. The review focused on the success and active implementation of the KQMH not only in government health facilities but also in private and faith based (FBO).

The reviewed KQMH will not only include quality management but also other topics like infection prevention control, occupational health and safety and health care waste management. Handling of donations is also addressed.

The previous KQMH was not effectively implemented in Kenya's health facilities due to insufficient funds, weak marketing strategies and inadequate training and support 'on the ground'.

Quality management systems (QMS) in health care facilities is a key component in the CHAK 2017 – 2022 strategic plan. CHAK supports its member health units with training, support and capacity building in quality management and has achieved significant progress to date.

Quality in healthcare can potentially increase the competitiveness of CHAK member health units, improve customer satisfaction and hence increase the market share of the CHAK network.

The CHAK quality management program is supported by Bread for the World and includes one full time professional advisor.

Coverage

The programme will be implemented in large CHAK health facilities as a start and later be rolling out to smaller facilities.

Objectives of the project

The objective of the project is to improve the overall quality in health care systems and of health care services in CHAK member units. CHAK will also participate in regular government regulatory meetings.

Implementation strategy

1. Capacity building and support
2. Facility based quality improvement officers or teams
3. Integration of KQMH into health facility strategic plans
4. Continuous follow up with interested health facilities
5. Yearly quality improvement meetings with health facilities and identification and adoption of best practices
6. Advocacy in important strategic meetings such as the CHAK AGM, CHAK Times, among other forums.

Project perfomance

A follow-up work plan from the trainings in 2015 was initiated in 2016 to ensure efforts to scale up quality management in CHAK member health facilities were sustained.

By the end of 2016, five CHAK health facilities had appointed quality officers. These were:

- AIC Cure International
- PCEA Chogoria Hospital
- PCEA Tumutumu Hospital
- Tenwek Mission Hospital
- Oasis Medical Centre

Each quality officer drafted a work plan for 2016. The project is working with them to ensure the work plans are implemented.

In 2016, four health facilities were assessed for quality management practices, a report compiled and shared with CHAK and the health facility managements. These facilities are:

- Tenwek Mission Hospital

- Oasis Medical Centre
- PCEA Chogoria
- AIC Litein

Quality officers' forum

In the first half of 2016, a yearly follow up meeting with quality officers working in the CHAK network was held at PCEA Tumutumu Hospital.

It was found to be highly informative for all participants and will be continued in the coming years. It is anticipated that the number of quality officers attending will also increase.

Quality officers from the following health facilities were present at the forum:

- PCEA Chogoria Hospital
- AIC Litein Hospital
- Tenwek Mission Hospital
- Oasis Medical Centre
- AIC Cure International Hospital
- PCEA Tumutumu Hospital

Support supervision

Because of the challenges with implementation of the fairly new program it was decided to conduct support trainings and workshops in interested health facilities.

This meant more health workers would be made aware of quality improvement and be directly included in the implementation process. Due to limited staffing in the project, a decision was made to begin with two interested health facilities in 2016.

PCEA Chogoria Hospital expressed interest in developing a quality manual, control of documents and standard operating procedures.

Two workshops were held with all heads of departments of PCEA Chogoria Hospital. The quality manual has already been completed. The control of document was completed and an onsite workshop held. Each department wrote a standard operating procedure.

AIC Litein expressed interest for support of the laboratory department. The extent of this support included recommendations on the general structure, equipment listing and printing of manuals, chemicals and their storage and disposal and cleaning schedules. This was done for both the health facility and training college, which also has a laboratory section.

Development of quality documentation was started. Control of documents were also done and trainings carried out. Additionally, standard operating procedures were also developed. No Quality Officer is currently employed, hence the process must be followed up by CHAK and the facility's laboratory department.

Advocacy meetings

KQMH

Review of the KQMH continued in 2016. CHAK health quality management systems advisor has been involved in the process.

Further, the Ministry of Health is developing a quality improvement curriculum intended to be implemented in medical schools and universities. CHAK is represented in the development process and related information forwarded to CHAK training institutions.

Infection prevention

The CHAK Health Quality Management Systems advisor participates in quarterly infection prevention and control meetings at the MOH.

Occupational safety

CHAK also participates in the quarterly occupational health and safety meetings or conferences called by MOH.

Challenges

It was observed that health facilities participating in the KQMH training faced several challenges including:

- Resources to support implementation not factored in the facility budget
- Weak management support
- Beginning the quality improvement process in a health facility can be quite a challenge.
- Lack of interest from other departments
- Undefined responsibilities
- Some health facilities do not have a full time quality officer.
- High staff turn over at the health facilities
- Constant follow up with all health facilities is difficult as the project has only one staff.
- Budgetary constraints in the project

Lessons learned

1. To ensure successful continuation of skills transfer, direct follow up visits and meetings with health facilities and quality officers is crucial.
2. The positive outcome of the trainings has encouraged other member health facilities to attend future exercises.
5. When trying to implement quality management, it is necessary to include not just quality officers in trainings, but also management, who are the decision makers in the facilities.
6. It is important to work closely with other players in quality management in the country to avoid dublication.

Way forward

- Training of smaller CHAK health facilities which have expressed interest.
- Continuation of on-site support workshops. Oasis Medical Centre in Kilifi will be supported in 2017.
- Continuation of the quality officers' forum as well as expansion of discussion areas.
- Continued participation in MOH meetings
- Follow up of trained health facilities, initiation of review and audit processes for the facilities
- Discussion of quality improvement strategies and best practices in strategic forums such as the CHAK Annual Health Conference

Human resources for health support to MHUs

The ability of a country to meet its health goals largely depends on the knowledge, skills, motivation and deployment of the people responsible for organizing and delivering health services.

CHAK in its Strategic Direction 6 has identified human resources in health as a critical component of its support to member health units. Some of the key interventions prioritized in the year 2016 were:

Study on effects of HRM policies in FBOs

CHAK collaborated with different partners and stakeholders in the health sector to undertake a study on the effects of human resource management policies in faith based organisations on the workforce and family planning/HIV service delivery.

The study with support from USAID Capacity Plus was conducted between 2014 and 2015. It noted sustained progress in implementation of human resource management policies, professionalization of human resources and improvement in human resource life cycle practices in MHUs.

The study however noted challenges in performance management, recruitment and hiring practices as well as employee compensation and benefits.

The findings were disseminated to 24 hospitals who participated in the study. Dissemination and implementation of the study findings has formed the basis of technical supportive supervision to bridge the identified gaps.

Clinical placements and mentorship guidelines

Clinical placements and mentorship guidelines were developed to give direction to CHAK secretariat and its affiliate institutions involved in strengthening clinical placement.

They were specifically to standardize and improve the processes of clinical training and mentorship in order to produce competent health professionals who are responsive to the health needs of Kenyans.

The guidelines are a useful resource for leaders and managers of training institutions and health facilities providing clinical placement opportunities for students.

Supportive supervision

CHAK has continued to offer technical supportive supervision in human resource management to MHUs. The main aim of this support is to strengthen MHUs to manage and develop their workforce in order to attract and retain competent staff. At the same time, MHUs are encouraged to comply with health sector regulatory requirements.

Supportive supervision provided an opportunity

to discuss pressing challenges within the facilities and share opportunities available to better address HRH issues especially on compliance and emerging issues. Best practices were also shared and better ways of maximizing available resources to better operations through a motivated workforce sought.

In 2016, over 40 facilities were supported. During the visits guidance was provided on changing labour legislation, HRH tools and usage, regulation, HR practices at the facility and HRH profiling. The discussions also provided linkages to peer support.

Labour disputes

The health sector has experienced increased agitation by health workers demanding recognition, better terms and conditions of service among other issues.

Implementation of The Kenya Constitution 2010 led to devolution of health services to the counties, which is contentious, especially for health workers.

This has led to increased agitation by unions and associations with the climax being the 100-day national doctors' strike.

The strike led to collapse of the public health sector, desperation of patients and their families, collapse of training, shift of workload from public to FBO and private health facilities and compromised quality of services.

CHAK was not spared with doctors in some MHUs threatening to join the strike in solidarity with their counterparts in the public sector.

Most seconded medical doctors and consultants resigned and joined the strike. Medical officer interns posted to CHAK hospitals also joined the strike, some giving reasons of victimization and threats from their striking colleagues.

In response, CHAK convened three separate consultative forums for member hospitals. These were geared towards sensitizing and helping health facilities appreciate the changing industrial landscape, providing opportunity to discuss the implications of unions and strategizing on how to deal with disruption of medical officer internships.

The forums recommended involvement of the church in resolving the doctors' stalemate by praying for the country, offering to mediate in the process, seeking support for FBOs from both national and county governments and providing spiritual and moral support to the workforce.

Church leaders took up the challenge for advocacy which led to the final mediation process and return to work formula.

Some of the accruing benefits from the consultative forums included not only strengthened partnerships and support from counties on secondment of health workers and provision of commodities and supplies but also recognition of the role of FBOs in ensuring the health of all Kenyans.

CHAK under the umbrella of the Churches Group of the Federation of Kenya Employers successfully negotiated a two-year collective bargaining agreement with the Kenya Union of Domestic, Hotels, Educational Institutions, Hospitals and Allied Workers Union (KUDHEIHA).

The final document has been signed by the key stakeholders, including CHAK, on behalf of members. The signed CBA is at the point of registration with the Labour and Employment Court (Industrial Court).

Medical education

Introduction

CHAK continues to play a key role in medical education in Kenya.

CHAK has within its membership, Medical Training Colleges providing diploma level education for registered nurses. CHAK represents the interests of these colleges in the Board of the Nursing Council of Kenya.

There are a total of 13 Medical Training Colleges affiliated to CHAK member health units. The colleges offer mid-level training in nursing, clinical medicine, laboratory technology, nutrition and dietetics at basic level among others.

Training programmes have been established for Clinical Medicine at SDA Kendu Hospital, laboratory technologists at AIC Litein Hospital and anaesthesia and emergency nursing at AIC Kijabe Hospital.

Specialised training has continued for general surgeons at Tenwek Hospital and Kijabe Hospital through a fellowship programme delivered in collaboration with PAACS and COSESCA.

AIC Cure International is offering a fellowship programme in orthopaedic surgery. Bethany Kids Hospital at Kijabe offers Paediactric Pneurosurgery Course for Surgeons.

Additionally, CHAK facilitates in-service continuous professional development through workshops, conferences, seminars, mentorship and on-site supportive supervision through staff and partners including collaboration with MOH.

CHAK has continued to advocate for FBO Medical Training colleges to access Higher Education Loans Board support through Afya Elimu Fund. The fund targets needy students in middle level training colleges to enable them access and complete their training. Students in FBO MTCs have continued to benefit from the partnership, reducing the dropout rates due to lack of school fees.

CHAK has also forged strong partnerships with regulatory bodies such as the Kenya Medical-Practitioners and Dentists Board, Clinical Council, Kenya Medical Laboratory Technologists and Technicians Board and other professional bodies and associations involved in medical education to ensure compliance to regulation and professional ethics.

Doctors' and clinical officers' internship

The demand for medical education in Kenya has grown tremendously over the years. In 2016, CHAK facilitated the selection process for doctor interns seeking to join accredited member health units. Interviews for the doctor interns were held at Moi, Nairobi, Kenyatta and Egerton universities, with students from Kampala International University (Uganda) and Ukraine participating in the process.

We look forward to expanding the process to other universities like Maseno, which has es-

Interns posted to CHAK accredited facilities in 2016

Hospital	Medical Officer	Clinical Officer
AIC Kijabe Mission Hospital	10	12
AIC Litein Mission Hospital	8	8
AGC Tenwek Mission Hospital	11	8
Maua Methodist Hospital	8	8
PCEA Tumutumu Mission Hospital	5	9
PCEA Kikuyu Mission Hospital	9	8
PCEA Chogoria Mission Hospital	10	14
Kendu Adventist Hospital	4	4
Total	**65**	**71**

tablished a relationship with Sagam Community Hospital.

Competitive selection of Medical Officer interns was made possible by CHAK's strong relationships with deans' offices in the respective medical schools. The number of Medical Officer interns in CHAK accredited centres has been growing gradually.

Posting of doctor interns for 2017 may however be delayed due to the disruption occasioned by the 100-day doctors' strike.

The government has also continued to post clinical officer interns to CHAK facilities as per accreditation by the Council of Clinical Officers, Kenya. CHAK is working towards a coordinated recruitment and selection mechanism for clinical officers similar to the doctors' one.

Below is a summary of the medical and clinical officers posted to accredited CHAK facilities in 2016.

Health Management Information Systems

CHAK HMIS Software

CHAK has embraced advancements in information technology and developed a responsive customized Hospital Management Software built on the CARE2X and WebERP open source systems that has been named CHAK Hospital Management Software (CHMS).

This innovative software was initiated to respond to a demand by member hospitals who were frustrated by the cost, inadequate performance and lack of dependable support for other solutions that were offered off-the-shelf.

By the beginning of 2017, the Health facilities using the software in the various CHAK regions were:

Nyanza and South Rift Region

- Hope Compassionate Health Services – Homa Bay County
- AIC Litein Hospital – Kericho County
- Adventist Nyanchwa Hospital – Kisii County

Western and North Rift Region

- AIC Kapsowar Hospital – Elgeyo Marakwet County
- RCEA Plateau Hospital – Uasin Gishu County
- Friends Lugulu Hospital – Bungoma County

Nairobi ,Central, South East & Coast Region

- Oasis Medical Centre – Kilifi County
- Mombasa CBHC – Mombasa County
- ACK St Lukes Hospital, Kaloleni – Kilifi County
- St. Joseph Shelter of Hope Voi – Taita Taveta County
- AIC Githumu Hospital – Murang'a County
- ACK Mt. Kenya Hospital – Kirinyaga County

Eastern and North Eastern Region

- Methodist University Health Centre – Meru County
- Maua Methodist Hospital – Meru County

These facilities are at different levels of the software's implementation. Each health facility presents a unique environment, needs and system uptake timeframe. The system has helped the health facilities to achieve the following among others:

- Improved patient turnaround time
- Increased revenue collection due to proper monetary accountability
- Easily accessible patient historical information
- Improved inventory management
- Comprehensive accounting that follows international accounting standards
- Adherence to international health standards such as ICD-10 coding
- Seamless paperless workflow
- Easy compilation of accurate medical reports for the Ministry of Health such as morbidity and mortality reports
- Accurate and efficient payroll preparation
- Real time reports to support administrative functions and management in decision making
- Accurate and reliable debtors database and debtors control

There is growing demand for CHMS uptake by MHUs. CHAK is thus challenged to march capacity with the demand while ensuring high quality. The need to build sustainability from domestically generated resources has also been dis-

cussed. Cost sharing installation, training and maintenance fees were discussed by EXCO following recommendation from CHAK Management. These will gradually be introduced from 2017.

OpenMRS

Within the year, CHAK continued the process of developing another hospital software based on OpenMRS in conjunction with AIC Kijabe Hospital.

The project has received technical support from two expatriate programmers and a university intern. The software has been developed to a point where the first modules have been piloted at Kijabe Marira Clinic in Uplands and plans are at advanced stage to initiate another pilot at Tigoni District Hospital.

The process of development will continue as lessons are learnt from the piloting process. AIC Kapsowar Hospital has also taken up the system for implementation while further development was being undertaken.

CHAK Document Management System

The system has been installed at CHAK Secretariat and is used to support documentation in grant management. It has enhanced efficiency in financial reporting, review and feedback in grant management as follows:

- Easy and Fast access to information
- Secure storage of information
- Sharing information and documents with members without the hustle involved in movement of hard copies of documents
- Reduces the cost of managing records or documents
- Simple method of storing documents
- Facilitates organization of documents for ease of retrieval

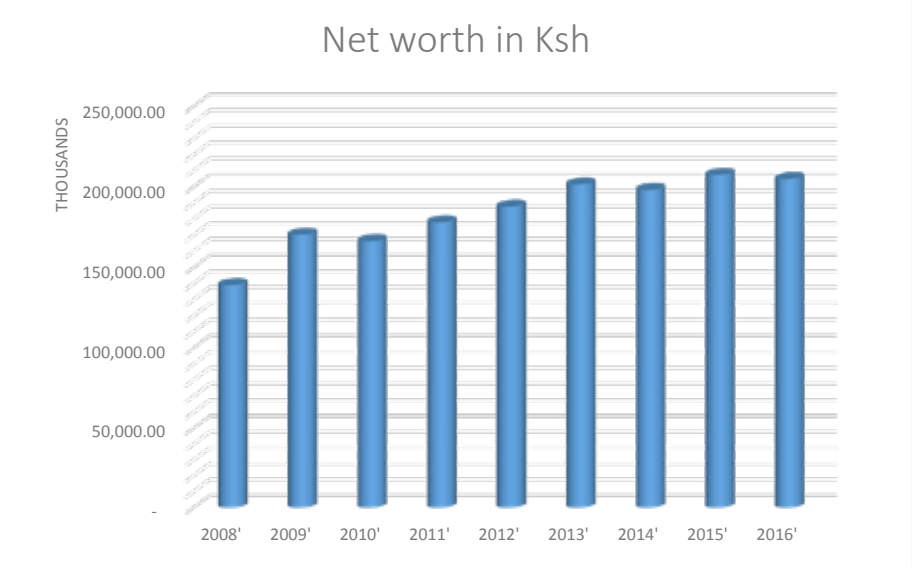
All CHAP implementing sites were supported to transmit their monthly reports through Alfresco online CHAK system to the CHAK Document Management System.

Financial Report 2016

Net assets growth

The Associations net asset book value recorded a decrease of 1.23 per cent from Ksh207.5 million in 2015 to close at Ksh204.9 million in 2016. There were no major capital or equipment purchased during the year. The decrease is attributable to depreciation charge for the year and a deficit of Ksh1.6 million realized during the year on the consolidated operations.

It is also worth noting that the land on which offices stand has been fully amortized and we expect value to increase when renewal of lease process is completed and revaluation done.



Net assets growth in 2016

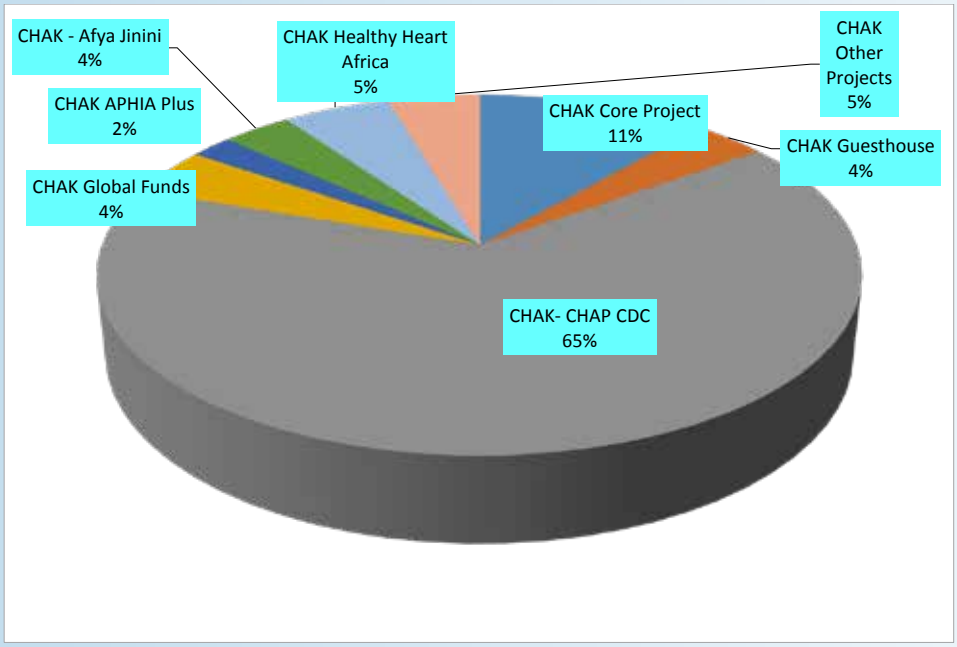
Total revenue

The Associations gross revenue increased from Ksh948.9 million in 2015 to close at Ksh953.2 million in 2016. The good performance was as a result of increased funding to the CDC HIV project which contributed 65 per cent of the total revenue. The other sources included Bread for the World from Germany (11 per cent), Global Fund projects (4 per cent), CHAK Guesthouse and Conference Centre (4 per cent), Healthy Heart Africa project funded by Astra Zeneca (5 per cent), USAID HIV & Family Planning projects (6 per cent) and others 5 per cent. The table below shows contributions by funding category.

Sources of Funds in year 2016- Project by Donor	Ksh	USD=Ksh100
CHAK Core programme supported by Bread for the World	50,463,290.00	504,632.90
CHAK E2A Family Planning funded by USAID	249,238.00	2,492.38
CHAK National HCTS program	11,861,963.00	118,619.63
CHAK Healthy Heart Africa(HHA) funded by Astra Zeneca	56,644,715.00	566,447.15
CHAK CCIH FP Advocacy Project funded by Gates Foundation	2,069,540.00	20,695.40
Human Rights Support by Stiftung Open Society Institute	7,576,291.00	75,762.91
CHAK Malaria Project - Global Fund Malaria R10 AMREF	30,028,738.00	300,287.38
CHAK TB Project- Global Fund NFM through AMREF	11,135,213.00	111,352.13
Global Fund TB - ACF Mombasa County	1,071,060.00	10,710.60
CHAK BOP Diabetes Management - DANIDA and Novo Nordisk	6,525,067.00	65,250.67
CHAK Guesthouse and Conference Centre operations	38,786,125.00	387,861.25
CHAK Core Budget - Own Contribution	52,094,805.00	520,948.05
CHAK HIV&AIDS Project(CHAP) funded by PEPFAR- CDC	616,885,817.00	6,168,858.17
CHAK Family Planning funded by Packard Foundation	21,311,750.00	213,117.50
CHAK- Norvatis Access Program	5,234,893.00	52,348.93
CHAK Afya Jijini funded by USAID through IMA WorldHealth	24,607,202.00	246,072.02
CHAK APHIA Plus Kamili funded by USAID through JHPIEGO	16,633,377.00	166,333.77
Total Funds Received during the Year	**953,179,084.00**	**9,531,790.84**

Contributions by funding category

The pie chart below shows contributions of income by project



Income by project

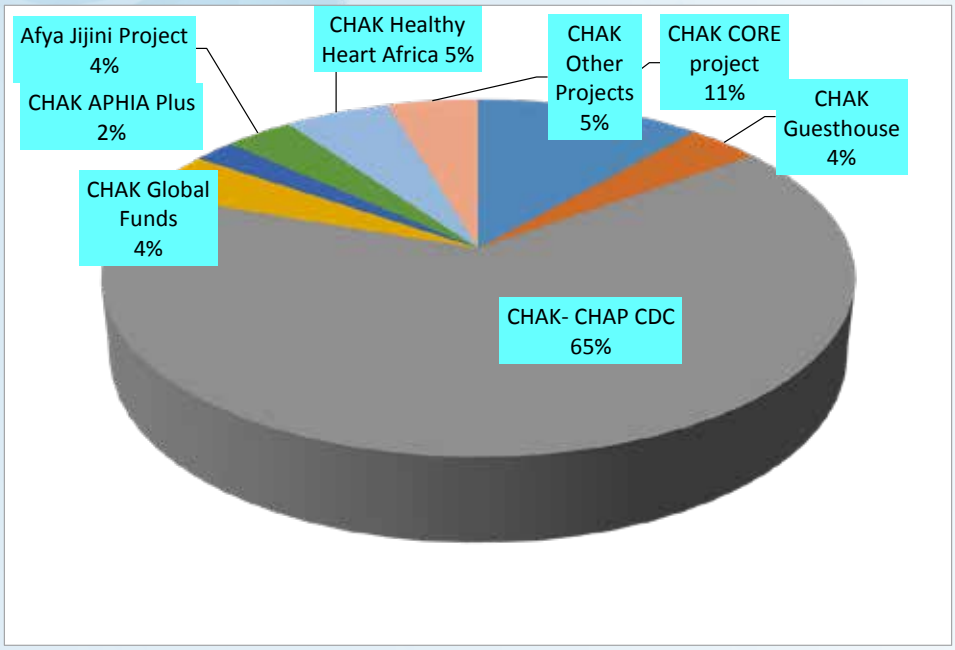
Total expenditure

The association expended Ksh951.8million in implementing various project activities. Overall, CHAK managed an expenditure over income at a rate of 99 per cent or burn rate of 99 per cent. This meant that every money received was put into use in accordance with budget and implementation workplan. All efforts were put in place to ensure expenditure was consistent with budget and in line with funding agreements. The table below shows expenditure by project category.

Expenses by project	Ksh	USD=100
CHAK Core program	108,165,139.00	1,081,651.39
CHAK Guesthouse	34,825,010.00	348,250.10
CHAK- CHAP CDC	621,486,900.00	6,214,869.00
CHAK Global Funds	40,563,990.00	405,639.90
CHAK APHIA Plus Kamili	19,939,994.00	199,399.94
CHAK - Afya Jijini	32,713,450.00	327,134.50
CHAK Healthy Heart Africa	50,582,787.00	505,827.87
Other projects	43,609,606.00	436,096.06
Total	**951,886,876.00**	**9,518,868.76**

Expenditure by project category

The pie chart below shows percentage of expenditure by project category.



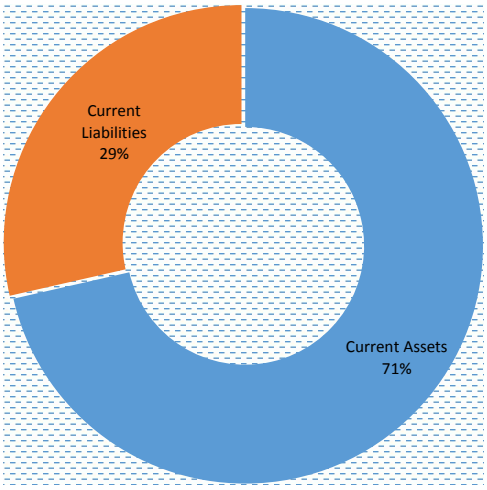
Expenditure by project category

Liquidity ratios

The Association maintained a cash ratio of 2.4:1. Total current assets were Ksh163.82 million while current liabilities were Ksh65.53 million. This means that the liabilities can be paid twice without causing any cash flow problems. The diagram below shows asset strength in terms of liquidity proportions.

Current Assets	163,817,843.00
Current Liabilities	65,532,372.00

Asset strength in terms of liquidity proportions



Pie chart showing current assets at 71 per cent compared to current liabilities at 29 per cent.

CHAK guesthouse and conference centre

The gross revenue increased from Ksh30.60 million in 2015 to close at Ksh38.8 million in 2016, representing an increase of 28 per cent. Similarly the net profit for the year increased from a loss of Ksh0 .995 million in 2015 to close at a profit of Ksh3.961 million in 2016.

The good results were as a result of a stable business environment and higher business volume due to enhanced marketing strategies targeting both local and international clients.

External audits and reviews

During the year 2016 , CHAK was externally audited and received unqualified audit reports. Several audits and assessments were conducted as follows:

1. CHAK core, Guesthouse and Conference Centre and Bread for the World project audits were conducted by Mazars CPAK
2. The CHAK-CHAP CDC project was audited by PriceWaterHouse Coopers CPA
3. CHAK Healthy Heart Africa Project was audited by PriceWaterhouseCoopers CPA
4. CHAK Global Fund projects were audited by KPMG CPA

There were also other external assessments conducted by AMREF for Global Fund TB and Malaria projects, business systems review by CDC Kenya and end-term evaluation of CHAK Strategic Plan 2011-2016 conducted by a team of consultants led by Prof. Dan Kaseje.

Feedback from these evaluations is utilized to further improve internal control systems.

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